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THE JOURNAL  
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*AN ANALYTICAL RECORD OF CURRENT LITERATURE RELATING TO  
THE THROAT AND NOSE*

EDITED BY  
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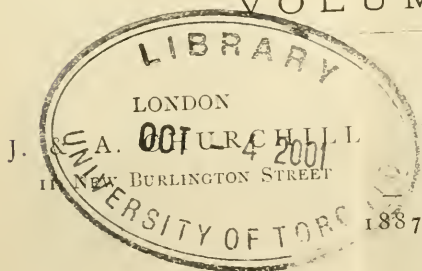
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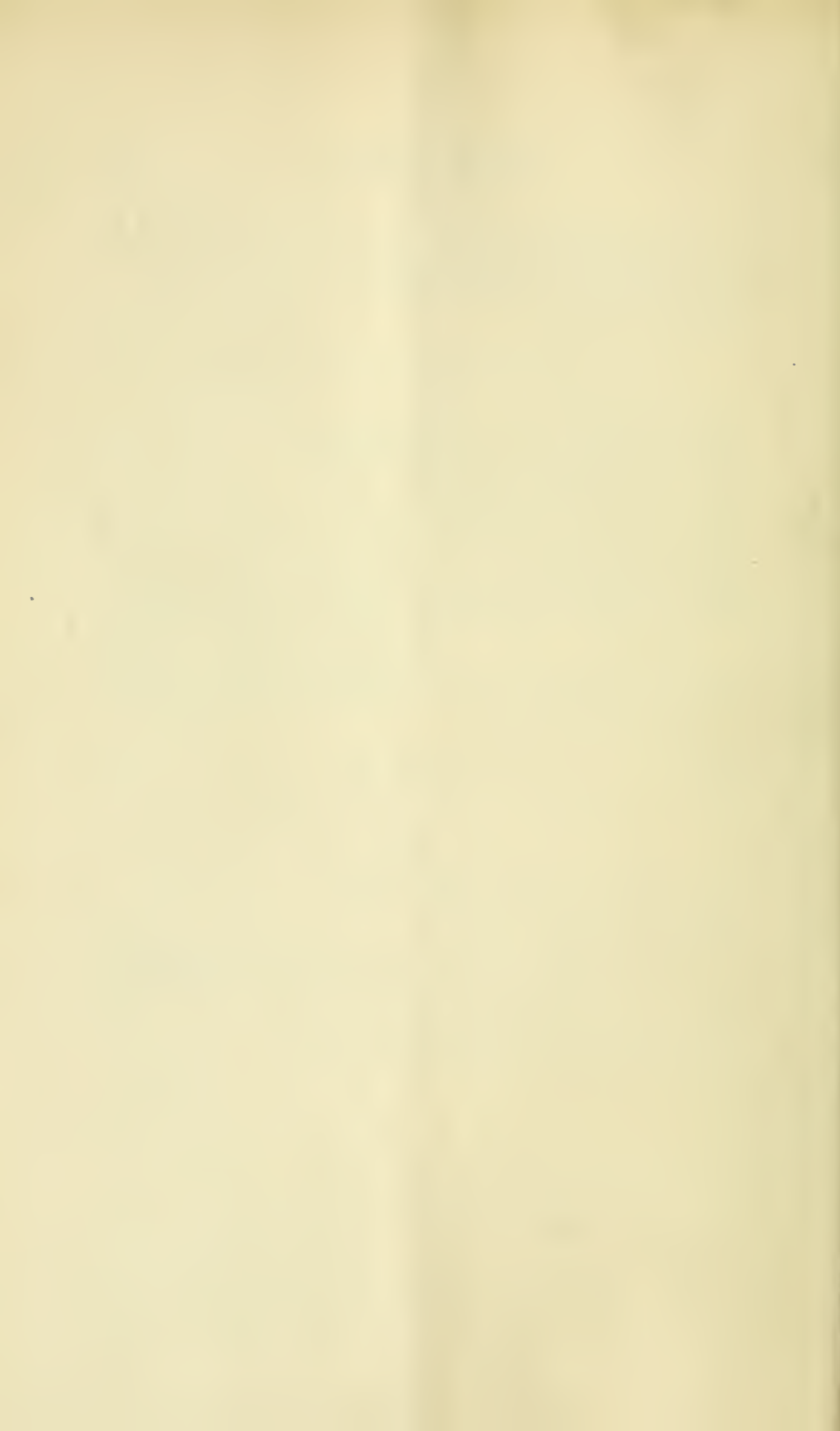
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INTUBATION OF THE LARYNX.

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“By intubation of the larynx is meant the insertion into the larynx through the mouth of a tube devised and perfected by Dr. Jos. O'Dwyer, of New York.” The set of instruments used by Dr. O'Dwyer consists of a gag, five laryngeal tubes, an applicator, extractor, and a gauge. The tubes range from  $1\frac{3}{4}$  in. to  $2\frac{1}{2}$  in., the calibre being  $\frac{1}{8}$  in.  $\times$   $\frac{1}{4}$  in. in the largest, and not more than half this in the smallest. At the upper extremity is an eye for silk thread. Jointed obturators fit each of these tubes, to hold them during introduction. The rounded lower extremity perfectly closes the tube opening, preventing injury to the soft tissues during introduction. Into the upper extremity is screwed the applicator. A sliding tube, fitted on to the stem and covering it, on being pushed forwards with the thumb, releases the obturator, so that it may be withdrawn and leave the tube in position. The extractor used for removing the tubes is constructed on the principle of a dilator. The closed blades are passed into the tube, and by depressing the lever with the forefinger, the blades open and press securely against the sides of the tube. The method of performing the operation is as follows:—

The child is wrapped in a blanket or shawl, so as to pinion the arms, and set upright on a nurse's knee, facing the operator. The mouth is held open by a gag, and an assistant holds the head. The left index finger, passed across the base of the tongue, hooks up the epiglottis, and serves to guide the tube into the larynx. The handle of the applicator may, as O'Dwyer recommends, be held towards the sternum until the pharyngeal wall is reached; the point is then directed downwards and forwards along the inner edge of the index finger. It is necessary to carry the handle high and direct the tube forwards, otherwise it will be passed into the cesophagus. Though all haste is desirable, ten to twenty seconds may be allowed for this portion of the operation, and, if then unsuccessful, the applicator should be withdrawn, and after a short rest the operator may try again. If the tube



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is in the larynx, cough will be immediately produced. The operator should now push forward the slide, so as to disengage the obturator, which is then withdrawn. If the operation is successful, easy respiration is at once established. Now cut one end of the silk thread; pass the finger behind the epiglottis and hold the tube while the thread is withdrawn. The tube is very exceptionally stopped by secretions, but, if so, must then be withdrawn. It is sometimes expelled by violent coughing. The withdrawal is not so easy as it would seem. It may be facilitated by pressing the larynx backwards and upwards with the left thumb. An anæsthetic, however, may be required for removal. The force necessary to insert the tube is minimal. The method should not be held entirely to supplant tracheotomy, which must still be done in exceptional cases, though limited to certain extreme conditions.

Intubation is particularly valuable for cases of diphtheritic croup in young children under three and a half years, and for cases in older children where it may be desirable to defer tracheotomy, in cases where skilled nursing is not procurable, in others where consent cannot be obtained for tracheotomy, in cases of severe spasmodic croup in children less than ten years of age, and for simple non-diphtheritic stenosis in children. It may also be serviceable in adults for laryngeal stenosis (Fletcher Ingals, *Journal American Medical Association*, February 6, 1886). The method was applied in fifteen cases of diphtheritic croup of the larynx reported by Dillon Brown (*New York Medical Record*, April 10, 1886), without regard to the hopeless condition of the patient, the tube never being introduced until the dyspnoea was most urgent. All the cases were foundlings; one-third were babies of sixteen, twenty-three, eleven, twelve, and five months respectively—an age at which recovery from tracheotomy is extremely rare. Two cases had tuberculosis; one was ricketty and had uræmic convulsions three days after disappearance of all laryngeal obstruction. Of these fifteen cases there were four recoveries. The head or shoulder of the tube does not rest upon the vocal cords, but just above them on the ventricular bands. There is never any ulceration of the cords, but may be slight ulceration about the head and lower end of the tube when retained for long, but this is harmless. There is not the slightest danger of the tube slipping into the trachea. In most cases food is well taken from the beginning, but it may be necessary to feed very young children by a tube.

Waxham, of Chicago, in his first record of seventeen cases had eight recoveries; Fletcher Ingals reported two cases, both fatal;

and Dr. W. P. Northrup, one successful case. This operator has lately recorded the operation on nine patients, of whom four recovered, and these were all suffocating from laryngeal stenosis. Of those ending fatally, two died of extension downwards of the diphtheritic process into the bronchi, one of well-developed pneumonia, one of sudden heart-failure, one of malignant diphtheria. Hance, of New York, has performed the operation in five cases, three of which died, and one made perfect recovery. In one fatal case the tube was coughed up, and subsequently swallowed, being found *post mortem* in the stomach; in two others there was sudden and complete stoppage of respiration, probably due partly to blocking of the tube by secretion, and even more to the falling back of the tongue. This operator prefers intubation to tracheotomy, for various reasons, which are set out in his paper (*New York Medical Journal*, October 2, 1886). Dr. Cheatham, of Louisville, used intubation in four cases: three were very advanced, and, though followed by immediate relief, ended fatally; one case recovered perfectly. Dr. Cheatham gives the following statistics:—

W. P. Northrup . . . 12 cases.	Dr. Strong . . . . 7 cases.
C. P. Caldwell . . . 3 „	Dr. Richardson . . 10 „
E. F. Ingals . . . 5 „	Dr. Waxham . . . 58 „

Total, 95 cases, with 28 recoveries, or 29·47 per cent. The cases tracheotomized averaged five years and one month in age, and yet only showed 18·95 per cent. of recoveries. Dr. Waxham says that of 58 cases, 20 were already moribund. Out of 83 cases he has had 23 recoveries, a percentage of 27·7. He has since added 13 cases with 6 recoveries. These now number 96 cases with 29 recoveries, or a percentage of 30½. Dr. O'Dwyer has reported 48 cases, with 12 recoveries; 25 of these were foundlings. For the removal of the tubes, Dr. Cheatham suggests that, in some cases, inversion of the patient is all that is necessary, or inversion with a sharp blow on the back, or touching the soft palate or pharynx while the patient is inverted. Failing these methods, the extractor may be used (*American Practitioner and News*, November 13, 1886).

The operation is not limited to membranous croup, since Dr. Strong has performed it successfully in a case of acute catarrhal laryngitis (*Medical and Surgical Reporter*, March 20, 1886). In an editorial article in the *New York Medical Record*, April 24, 1886, it is remarked that “we thus find that Dr. O'Dwyer's method already compares very favourably with tracheotomy as regards the saving of life, while certainly, to consider it from an æsthetic point of view, it is much to

be preferred . . . If intubation of the larynx proves itself to be as valuable as these first essays would lead us to hope, it will be accounted one of the great advances in this age of medical discoveries, and we may only wish that such will be its fate."

It is but fair to say that Dr. C. G. Jennings, of Detroit (*American Lancet*, November, 1886), states that his experience is rather unfavourable and leads him to distrust the operation, particularly for children over three or four years of age and having mild diphtheria. He thinks that tracheotomy will save every case that intubation will, and a great many more. This is hardly the recorded experience of the many other operators mentioned before. Dr. Jennings thinks, however, that it may replace tracheotomy for very young children, under fifteen or sixteen months; and also thinks that the tubes are a guide to tracheotomy. His recorded cases, however, only amount to four.

Northrup (*New York Medical Record*, December 11, 1886) states that 165 cases, well reported and attested, prove intubation to relieve dyspnoea promptly and effectually, while the percentage of recoveries, reaching 28½ per cent., puts it in striking contrast to tracheotomy. His paper is a careful resumé of the question. We regret not to be able to refer further to it, since it reached us only after this article was already in print.

While congratulating Dr. O'Dwyer and our American *confrères* on the brilliancy of these first efforts, we cordially endorse the sentiments quoted above from the *New York Medical Record*.

R. N. W.

## THERAPEUTICS AND INSTRUMENTS.

**ELDER.**—Note on Cocaine. *Lancet*, No. XVIII. Vol. II. October 30, 1886.

THREE or four minutes after injecting a 10% solution under the skin (M xij), syncope, twitchings of face, falling of jaw, coldness of body, clammy perspiration, lividity—all the appearances of impending death. Several minutes afterwards consciousness recovered, with subsequent great prostration. ED.

**HALL, L. EMMETT.**—Cocaine in Whooping-Cough: Is its Use Safe in Young Children? *New York Medical Journal*, October 23, 1886.

THE author answers this question in the following conclusions:—  
(1) It must be used with great caution in young children, under all circumstances; (2) The spray is never to be recommended, since an uncertain quantity is given; (3) Solutions stronger than 4 per

cent. should not be used in children under two years; (4) In cases where it was tried, he failed to see any notable benefit; (5) Chloral seemed to be of very decided value in controlling symptoms due to cocaine.

**GARNETT, A. P.** (Washington).—**Inhalations of Muriate of Cocaine in Whooping-Cough.** *Journ. Amer. Med. Assoc.*, October 9, 1886.

OF a 6 per cent. solution of cocaine in chloroform, ten minims were inhaled from a wine-glass made warm by tepid water, the nostrils being kept closed. It was repeated every four hours. It relieved paroxysms, but did not cut short the disease.

The author has adopted this treatment extensively. In very young children the ten or twelve drops may be poured on to a handkerchief.

**MICHAEL** (Hamburg).—**The Therapeutics of Whooping-Cough:** *Subsection for Pediatrics of the 59th Meeting of German Naturalists and Physicians.*

LAST year the author originated a method of treatment by nasal insufflations of powders of pulv. resinæ benzoæ, chinin. sulph., and arg. nit. 1-10. Benzoin has an agreeable taste, no toxic effect, and is most serviceable. The author relates 250 cases in which this treatment was adopted. Of 100 carefully observed cases, eight had no further attack after the first insufflation. In three of these there was a return, and five were cured permanently. In 74 per cent. there was substantial benefit, no effect in 12 per cent., and increase of the cough in 14 per cent. 7 per cent. were cured in three days, 23 per cent. in less than twenty days; the rest occupied three to five weeks. In twenty cases there was improvement, with cessation of vomiting, epistaxis, and asphyxia. The best effects were observed in very new and very old cases. The duration of the treatment was fourteen days in fifty cases. The author's results are confirmed by the publications of Bachem, Guerder, Lublinski, Stoerk, and Ziem.

THE AUTHOR.

**SHURLY, E. D.**—**Observations on the Use of some of the Newer Remedies in Diseases of the Upper Air Passages.** *New York Medical Journal*, September 11 1886.

*Aconitine* was used as spray or pigment in twenty-five cases, embracing laryngeal phthisis, chronic pharyngitis, pharyngo-laryngitis, follicular amygdalitis, and pharyngeal neuralgia. As a local agent it is of little benefit in most cases, and is prohibitory on account of its unpleasant effects.

*Agaricin* apparently has no therapeutic effect when used locally.

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*Arbor Vite*, used as a spray of the fluid extract, caused disappearance of intra-laryngeal papillomata, used twice daily for three months. It was useless for a cystic tumour of the vocal cord. Its good effects may be due to its astringency.

*Ammonium Glycyrrhizæ* is of doubtful value as a spray, but is a good expectorant.

*Cannabine Tannate* is an astringent and local stimulant in nasal and naso-pharyngeal disease. It is very irritant when used pure, but with starch, or vaseline (2.5 gr. to the drachm), it is an excellent substitute for tannic acid, without its irritating effects.

*Cadmium Sulphate* is not superior to zinc sulphate or chloride.

*Cotoin* is a powerful irritant to the nasal and pharyngeal mucosa, and, when diluted with starch or sugar (1 part to 3 or 4), is better than anything, except galvanism, for atrophic catarrhs.

*Coniine Hydrochlorate* is of no value locally.

*Cocaine*. Sufficient is already known of this body.

*Daturine*,  $\frac{1}{100}$ — $\frac{1}{30}$  grain, used as a spray, frequently is of service in influenza.

*Ethyl Bromide*, as an inhalation for cough, is not quite so efficacious as chloroform, but causes less general anæsthesia.

*Hyoscyine*, used as hydrobromate, is inefficacious.

*Hydrastine* is useless.

*Iodol* does not arrest ulceration like iodoform, but causes slow improvement and healing.

*Papain* is of no service as a solvent in diphtheria.

*Muscarine Sulphate*,  $\frac{1}{30}$ — $\frac{1}{10}$  grain, as a spray, relieved dry catarrhs.

*Physostigmine Sulphate* relieved spasmodic stricture of the lower pharynx and œsophagus in doses of  $\frac{1}{120}$  grain.

*Pilocarpine Hydrochloride* is unserviceable.

*Piscidin*. A pigment of  $\frac{1}{120}$  grain to the drachm relieved a persistent tickling of the pharynx in a case of phthisis.

*Resorcin*. This was used with good effect in secondary and tertiary specific ulceration, ozæna, lupus eczematosa, ulcerating lupus, and herpetic pharyngitis. It is used as a spray or pigment, one part to four or six.

*Sanguinaria Nitrate*. It is useless locally, but is a good stimulating expectorant in doses of  $\frac{1}{10}$ — $\frac{1}{4}$  grain in syrup.



## DIPHTHERIA.

**MERCES.**—Diphtheria: its Treatment. *Lancet*, No. XVIII. Vol. II. October 30, 1886.

1. WITH marked depression, moderate elevation of temperature, and glandular enlargement; give first an aperient, then

R Iron perchloride ʒvj.  
Dilute nitric acid ʒij.  
Glycerine ʒj.  
Water to ʒvj.

ʒj. every two hours.

2. Patches may now be noticed, temperature and glandular swelling increased. Now administer an emetic,

Apomorphia ℥ iij.—℥ v.

The slough will be found in the ejecta. The dyspnœa will be much relieved. Continue the iron.

3. If the patient can use a gargle, order the following—

Chlorate of potash ʒj.  
Pure hydrochloric acid ʒss.

Mix in a six-ounce bottle, and while the nascent chlorine is being generated, fill up with water and direct an ounce to be used every third hour.

4. Maintain strength by milk, beef tea, &c. Alcohol is urgently demanded and must be given with a free hand. The temperature must be uniform, say 70° F. with a current of fresh air. Ed.

**GOMER DE LA MATA** (Madrid).—Tratimiento de la Angina diphterica y Crup. (Treatment of Diphtheria and Croup.) *Gaceta de Oftalmologia, Otologia y Laringologia*, No. VII. July, 1886.

THE author uses pilocarpin to promote detachment of the false membrane, applying it pure or mixed with glycerine carbolic acid: he insufflates with saccharate of lime; uses spray inhalations of lemon juice and lactic acid; uses ipecacuanha, or sulphate of copper; and rubs the chest, neck, and spine with camphorated ointment; and advises a nutritious diet. The patient should be placed in a well-ventilated room at a temperature of 16° C., saturated with carbolic vapour.

RAMON DE LA SOTA Y LASTRA.

**SHIRES, GEORGE.**—Insufflation of Iodoform into the Trachea after Tracheotomy for Diphtheria. *Lancet*, No. IV. Vol. II. July 24, 1886.

HE treated two cases by blowing 10 grains of iodoform (in the one), and 15 grains (in the other), into the trachea, by introducing an



## 8 *The Journal of Laryngology and Rhinology.*

insufflator down the tracheotomy tube. The insufflation was repeated every four hours. Perfect recovery. ED.

**WATSON, CAMPBELL** (Edinburgh).--*Diphtheria.* *Edin. Med. Journal*, No. CCCLXXVII. *November*, 1886.

DIPHTHERIA is primarily a local disease; there is not a so-called period of incubation: supposing it due to infection, however arising, like scarlatina, typhoid, or small-pox, it differs from these in one very important particular, that while any of these diseases seems to eliminate a mysterious specific pabulum, and so secures immunity from recurrence, diphtheria leaves the patient more susceptible to the disease for a considerable time; diphtheria is, further, parasitic and fungoid in character.

He advises gargles of pot. permang. (half a grain to an ounce of water), applied over the whole pharynx, using two or four ounces at a time, and repeating every two hours during night and day. As a spray to the respiratory passages he advises the same in a strength of one grain to the ounce. The disease is quickly mastered by this treatment, and meat-teas and milk are quite sufficient to sustain the patient. In constitutional disturbance he relies on soda sulpho-carbolate in 20-grain doses every four hours, for an adult; one grain for each year in children. ED.

**REIERSON, A. C.** (Copenhagen).—*On the Treatment of Nasal Diphtheria (Om Behandlingen af Naesediphteritis).* *Ugeskrift for Læger*, 4de Række, XIV. Bd., No. 33, 1886.

THE author gives an account of the treatment lately employed with good results in the Copenhagen Fever Hospital in cases of nasal diphtheria. The serious character of this form of diphtheria having been experienced (the author thinks that the pituitary membrane absorbs the micrococci of diphtheria much more quickly than any other mucous membrane, thus giving rise to serious general symptoms) and the usual treatment, by which either the false membranes were removed with forceps or antiseptic liquids injected in the nose, having proved unsatisfactory in results, or impossible in practice, the treatment by medicated bougies has been adopted. They are made according to the following formula:—

Cocain muriat	...	...	...	...	milligram, 10 à 15.
Boric acid	...	...	...	...	gram, 1.
Amyli	...	...	}	...	...
Gummi arab. pulv.	...	...		...	aa. centigram 10.
Glycerini	...	...	...	...	quantum satis.

The length of the bougie for grown-up persons and big children is 10 centimetres, the diameter 5 millimetres ; the same diameter will do for quite small children, the length being only a few centimetres shorter, but these bougies contain only 5 milligrams cocain (or even less for quite small children) and 65 centigrams boric acid each. They ought to be stiff and pointed at one end. They are introduced easily and cause hardly any pain or bleeding ; one is applied to each inferior meatus, and ought to reach as far as the naso-pharynx. When they are melted, the passage through the nose is often re-established at once, and the mucus and the false membrane are now easily removed by syringing through the nose ; but, if necessary, the introduction of the bougies is repeated, one hour being the usual time for them to melt thoroughly. The cocain acts partly by reducing the swelling, and partly by decreasing the irritation caused by the boric acid, which acts like permanent antiseptic irrigation.

HOLGER MYGIND.

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## NOSE.

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**BOVILL** (India).—**A Case of Rhinolith.** *British Medical Journal*, October 16, 1886.

THE patient was a Hindu, aged forty. The rhinolith occluded the left nostril, causing a sanious and offensive discharge, and there was facial paralysis, ptosis, and epiphora of the left side. The rhinolith was crushed and removed, and the fragments weighed four drachms, and when dried, 165 grains. The palatine process of the upper jaw-bone was atrophied on the right side from pressure by the stone. The ozæna and swelling subsided, and facial paralysis was ameliorated.

ED.

**WRIGHT.**—**On Some Forms of Nasal Obstruction.** *Manchester Medical Chronicle*, July, 1886.

1. **ECCHONDROSIS** or hyperchondrosis, resulting from injury, spontaneously or congenital, distinguished from deviation of the septum by examination of the other side, and from mere mucous thickening by its hardness and sharp outline. Only removal is effective.

2. Deviation of the cartilaginous septum. This arises in several different ways, may be congenital (though this is usually of the bony septum), from fracture, or dislocation, of either the ethmoid and vomer, or of the nasal spine of the upper jaw below. It may also be from

perichondritis, resulting in softening and subsequent deviation of a local patch of the septum. Adams's plan of treatment is all that can be desired.

3. Adenoid postnasal vegetations are a frequent cause of nasal obstruction. The author also calls attention to a special form of enlargement of the tonsils, which takes place, not towards the mid-line, but outwards and upwards between the pillars of the fauces and layers of the soft palate. They require the vulsellum and bistoury for their removal.

The author cites an unusual case of a boy of seven, in whom the nasal cavities, right up to the anterior nares, were stuffed full of adenoid vegetations, mainly attached to the septum. They were removed by scraping. ED.

**PREDBORSKI.**—Disease of the Nose causing Aphonia and Dyspnœa. *Gazeta Lekarska.*

A YOUNG Jewess, after a severe fright and nervous shock, lost the power of speech, and suffered from spasmodic dyspnœa; the catamenia also ceased. The attack was so alarming that tracheotomy was decided on, but the inhalation of chloroform gave relief, and the girl began to scream. In a few weeks' time the girl seemed better, but subsequently the symptoms recurred. The nose showed redness and tumefaction of the lower and middle left turbinated bones. Touching them produced pain, sneezing, and mucous discharge. Chromic acid quickly and completely restored the patient's health.

**FRENCH, T. R.**—The Effects of Diseases of the Nasal Passages on other Portions of the Respiratory Tract. *New York Medical Journal*, November 13, 1886.

THE author discusses three ways in which these effects arise—(1) by catarrhal discharges finding their way into the larynx; (2) indirectly, by causing the habit of mouth-breathing, and dry, cold, unfiltered air causing catarrhal inflammation by direct irritation; (3) by reflex irritation, and the production of such symptoms as laryngeal spasm, cough, and bronchial spasm. He holds with the theory of sensitive areas, but believes that the superior posterior regions of the nares quite as frequently give rise to reflexes as the inferior posterior regions, where, according to Dr. Mackenzie of Baltimore, they are most marked. The author quotes a case of asthma due to polypi confined to the upper portions of the nares. In long-standing cases of nasal obstruction he finds local treatment unsatisfactory so far as the asthma is concerned.

**KRAUSE** (Berlin).—*Die Nasalen Reflexneurosen insbesondere das Nasale Asthma und die experimentelle Trigeminus forsschung* (*Nasal Reflex Neuroses, especially Nasal Asthma, and the Experimental Study of the Trigeminus*). *Deutsch. Med. Wochens.*, 1886, No. XXXII.

THE author refers to some physiological observations of Holmgren, Wegele, Kratschaur, and Knoll, which prove a certain relation between the trigeminus and the respiratory function, and says that asthma must be considered due to a morbid increase of irritability of the sensory trigeminus fibres ending in the nasal mucous membrane, and which are consequently able thus to produce reflex attacks of expiratory impediment.

MICHAEL (Hamburg).

**FERRERI, G.**—*Reflex Phenomena of Nasal Origin, and the Injection under the Mucosa of Cocaine.* *Sperimentale*, September, 1886.

THIS is an accurate synthetic review, in which, however, one misses some Italian work, *e.g.*, Massei's Lectures on Vertigo and De Gennaro's Reflex Neuroses. The review ends with a description of an instrument adopted by Prof. de Rossi for the subcutaneous injection of cocaine in the nasal cavity and larynx. It is a Scarenzio syringe, with three rings on which is fixed a long steel tube slightly curved at the extremity, to which is screwed an ordinary gold needle for injection. In spite of the good work in the hands of the author, we do not see why we should, according to Ferreri, prefer it to the pencilling of cocaine, even for the rapidity of the effect. Indeed, in three or four minutes, pencilling produces anæsthesia. Moreover, although the application may be easier for the naso-pharynx, we do not know if the same can be said for the larynx. In every respect the idea is admirable, and if it assists in localizing or prolonging the laryngeal anæsthesia, the method will soon gain confidence.

MASSEI.

**BOBONE, T.**—*A Case of Spasmodic Sneezing: History and Remarks.* *Bollet. Prazzi*, July, 1886.

THE author alluded to one of the more serious reflex neuroses of the nose, resulting in a succession of sneezing fits at very short intervals. After having referred to the importance and extension of reflex phenomena taking origin in an affection of the nasal mucous membrane, he related a case under observation, sufficiently uncommon, seeing that on two occasions the attacks of sneezing followed each other so rapidly that the patient became cyanosed and collapsed, and his life in jeopardy; but with the supervention of vertigo the attack was cut short. Inspection of the nasal cavities revealed an

intense hyperæmia of the whole mucosa, as well as great swelling of the inferior turbinated tissue on both sides, so that it came in contact with the septum. He then made some remarks relative to the mechanism under which reflex actions are generated, and cited some of the different opinions on the subject, such as those of Hack, Fränkel, Mackenzie, and Baratoux. He said it was not yet settled what points of the nasal mucosa, when irritated, gave rise to reflexes, nor the nerves through the connections of which the reflex actions take place, nor what kind of alteration in the nasal mucosa was accompanied by the lower rather than the higher neuroses; but, for the rest, he shared the opinion of those who admit a sensitive zone, and that the irritation takes place through the trigeminus. From the case in question he was enabled to draw the following corollary; in many cases the tumefaction of the turbinated bodies, in contact with that of the septum, is not sufficient to give to the sensitive zone the property of exciting reflex action, but a concomitant and active state of hyperæmia of the mucosa is also necessary. Lastly, the author referred to treatment with the object of destroying the reflex manifestations. The galvano-cautery, according to him, was not superior to other measures, such as buginaria of iodoform and cocaine, from the anæsthetic and anœmizing properties of which he had obtained every benefit in the case under discussion. MASSEL.

**MAYS, T. J. (Philadelphia).—The Nasal Reflex—A New Method for Determining the Local Sensory Action of Drugs—A Preliminary Note.** *The Medical News*, November 20, 1886.

FIVE or six drops of the drug to be tested (a 1 or 2 per cent. solution) are dropped slowly into the nostril of a frog, at intervals of from three to five minutes, and the nasal reflex is tested by introducing the end of a very light wire into the medicated nostril and comparing it with its fellow of the opposite side.

Irritation in the healthy side will make the frog wince, blink, and make efforts to brush away the offending substance with the foot, while if the drug be one affecting sensibility the animal will permit even boring into the nose without pain. The method has been used to determine the local differences between theine and caffeine, and is very delicate and accurate.

**DE GENNARO, L.—Contribution to the Study of Reflex Neuroses of Nasal Origin, and of the Effects of Chronic Pharyngitis.** *Archiv Ital. de Laring., An. VI., Fasc. 3 and 4.*

THE scope of this publication is comprised in its title. De Gennaro



first refers to the authors occupied specially with the nasal reflex neuroses.

He then refers to two cases of his own. The first patient had spasm of the glottis, dyspnoea, cough, guttural voice, vertigo, &c., with a nasal polypus. This, once destroyed, all the reflex phenomena gradually ceased. The second had spasm of the glottis, deafness, and dyspnoea, through chronic rhino-pharyngitis. With local treatment the symptoms were ameliorated, although not eradicated.

Finally, the author returns to the pathogenesis, and distinguishes two classes of theories. In the first come those which limit the point producing the reflexes, and which he calls an empirical theory; while in the second are those which refer the reflex power to the whole nasal mucous membrane, and which he calls a pathological theory. His own views conform with the second class, because it agrees with the anatomy and physiology of the nose. But if the absence of a special constitution in the turbinated bones and septum condemns the theory of Hack, Baratoux, &c., that of Brebrion, &c., is not as much to be depended upon, since it should apply to all cases of nose disease.

The author believes that if the reflex phenomena pertain to the whole nasal mucous membrane, they must, on the other hand, be sustained by some other element extraneous to the nasal lesion, such as an hysterical or hyperæsthetic condition. This pathological agent, granted it already exists in the individual under the influence of the nose affection, would manifest itself in the form of a reflex neurosis. Thus the author is not far removed in his opinions from Rossbach, Heymann, Boecker, and others.

MASSEI.

**BÖCKER** (Berlin).—*Die Beziehungen der erkrankten Schleimhaut der Nase zum Asthma, und deren Behandlung.* (*The Relation of the Diseased Nasal Mucous Membrane to Asthma, and its Treatment.* *Deutsche Med. Wochensch.*, 1886, Nos. 26 and 27.

THE author summarizes his observations in the following theses:

1. Reflexes can be originated by every part of the nose.
2. The reflex irritation of the mucous membrane is independent of the corpora cavernosa (Hack).
3. The destruction of the corpora cavernosa does not arrest the reflexes.
4. The swelling of the lower turbinated body is physiological.
5. The reflex-arresting-power of large polyps does not exist.
6. Asthma is seldom associated with nasal polyps.



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7. Asthma can be originated under certain circumstances by all mucous membranes.
8. Asthma is usually produced by the bronchial mucous membrane.
9. Odours and psychical impressions can produce asthma.
10. Normally, asthma cannot be produced by the nose.
11. Trigemino-asthma is caused by morbid states of the nervous system.
12. The impossibility of respiring nasally may produce asthma.
13. Asthma occurring from "catching cold" is originated by swelling of the bronchial mucous membrane.
14. Hay fever asthma is produced by direct irritation of the bronchi.
15. Cavernous tumours, papillary growths, and adenoid vegetations often produce nightmare.
16. Asthma often is independent of nasal conditions.
17. The treatment of nasal affections can sometimes cure asthma.
18. Extended galvano-caustic operations on the nose are to be avoided.
19. Radical cure of asthma is seldom effected by mere removal of nasal polyps.
20. In the treatment of asthma, constitutional treatment is of the greatest importance.

MICHAEL (Hamburg).

**HUBERT.**—Ueber die Verkrümmungen der Nasenscheidewand, und deren Behandlung. (On Curvations of the Nasal Septum and their Treatment.) *Inaugural Dissert., München*, 1886.

A VERY careful review of the methods used to correct abnormal positions of the septum, and especially of two new methods of Prof. Jurasz; one, applications of the galvano-cautery in two cases; the other a method of compression with gossypium, useful for traumatic cases. This method has also been tried effectually in two cases.

MICHAEL (Hamburg).

**WÖLTERING** (Münster, i. W.)—Operation einer Knöchernen Nasenverengerung mittelst schneidender Knochenzange. (Operation for an Osseous Stenosis of the Nose with Cutting Bone Forceps.) *Monatsschr. für Ohrenheilk.*, October, 1886.

THE title is self-explanatory. The instrument, the illustration of which is given in the original article, seems to be complicated by a double articulation in an unnecessary manner.

MICHAEL (Hamburg).

**SCHMIEGELOW, E.** (Copenhagen).—Some Rare Cases of Defects of the Septum of the Nose. (Nogle Sjaeldnere Tilfaelde af Defekter; Naeseus Skillevaeg.) *Hospitalstidende*, 3 Rackke, IV. Bd., No. 42, 1886.

1. *Case of Congenital Defect of the Septum.*—In a man, aged sixty-four, the author found a deficiency of almost the entire cartilaginous part of the septum, of which only a small portion anteriorly was left. The aperture was almost round, except behind, where there was an angle corresponding to the junction between the vomer and the perpendicular plate of the ethmoid; it measured about 3 centimetres in anterior-posterior and about 2 centimetres in perpendicular direction. The patient had noticed this defect since childhood; any tubercular, syphilitic or traumatic origin, as well as lupus, could be excluded; there had never been any sign of disease of the nose, and the edges of the aperture were not cicatricial. There was no disfigurement whatever of the nose.

2. *Case of Defect of the Septum, caused by Traumatic Perichondritis.*—The patient was a lady, aged thirty-three years. A small opening was found in the cartilaginous portion of the septum, with partly ulcerated edges, caused by constantly picking the nose (which was the seat of chronic catarrh). Since early childhood the present opening had always been covered with crusts. The lady was otherwise in perfect health. Neither in this case was there any disfigurement of the nose.

3. *Case of Spontaneous Periostitis of the Osseous Part of the Septum,* in a healthy lady, aged forty-seven, where no syphilitic origin could be traced, and where iodide of potassium was used without any effect. The patient was under observation twice; the first time the probe showed denudation of the bone on the right side of the osseous part of the septum. After the process had quite stopped under local treatment, and the mucous membrane was regenerated, the patient came back a year later complaining of the old symptoms. This time a small perforation had been formed.

The author points out the fact that even larger defects in the cartilaginous septum do not cause any disfigurement of the nose.

HOLGER MYGIND.

**UNDERHILL** (Edinburgh).—Case of Agnathous and Hydrocephalic Fœtus. *Edin. Med. Journal*, July, 1886. Demonstration of Preparation before the Obstetrical Society of Edinburgh, 10th March, 1886.

THIS was an instance of the rare abnormality due to defect of the

lower jaw. The nose ended in a small tubular proboscis without any septum. The lower jaw was entirely wanting, and the mouth was represented by a small orifice just large enough to admit a probe, and hidden behind a rudimentary upper lip. This form of monster is rare in the human species.

HUNTER MACKENZIE.

## TONSILS, PHARYNX, &c.

**HINGSTON-FOX.**—The Functions of the Tonsils. *Journal of Anatomy and Physiology*, Vol. XX.

THE author concludes that the tonsils belong to the digestive tract, not the respiratory, and that their function is to reabsorb certain elements of the saliva, in the intervals of meals, which would otherwise be wasted.

**DOWNIE, WALKER** (Glasgow).—Hæmorrhage following Tonsil-lotomy. *Edin. Med. Journal*, August, 1886.

PATIENT, aged thirty-four, suffering from chronic enlargement of the tonsils. A slice of the right tonsil was removed by the guillotine, and from the left tonsil a projecting piece of tonsillar tissue was removed by the tonsil sickle. Only a little more blood than usual was lost at the time of operation, but six hours afterwards severe hæmorrhage set in. Notwithstanding the application of liquor ferri perchloridi (fort.) and ice, and the administration of ergot and hazel-ine, it recurred to an alarming extent again and again, and was finally arrested by the direct application of the actual cautery to the cut surface of the right tonsil. The hæmorrhage appeared to proceed from the tonsillar artery.

HUNTER MACKENZIE.

**MACKENZIE, H. W. G.**—On a Case of Acute Tonsillitis in a Subject of Tertiary Syphilis of the Pharynx. *Lancet*, No. XIV. Vol. II. October 2, 1886.

THE patient had syphilitic pharyngeal stenosis. The soft palate adhered to the posterior wall of the pharynx everywhere, except where a small passage was left to the right of the mid-line, and which led to the naso-pharynx. The swelling of the left tonsil in such an abnormal position gave it the appearance of originating in the posterior wall of the pharynx, as well as being continuous with the anterior (left) pillar of the fauces. A small œdematous swelling, suspended by a short thread-like pedicle, proved to be the remains of the uvula. The swelling occupied a portion of the right side. It proved to be located in the left tonsil. There was difficulty of diagnosis, and the

appearances suggested a malignant growth, or infiltrating gummatous deposit, involving the tonsil, soft palate, and posterior wall of pharynx. Under iodide of potash and guaiacum the attack quickly subsided.

ED.

**McBRIDE** (Edinburgh).—**Adenoid Growths of the Naso-Pharynx.** *Edinburgh Medical Journal*, August, 1886. Demonstration of Preparations before the Medico-Chirurgical Society of Edinburgh, 7th April, 1886. HUNTER MACKENZIE.

**DALBY.**—**Adenoid Growths in the Pharynx.** *Lancet*, No. XIV. Vol. II. October 2, 1886.

HE recommends a special steel nail; the mouth being opened by a Mason's gag. The head bent forwards permits the blood to escape by the nostrils. The instrument is so used as to allow the tip of the finger to be exposed, and thus to estimate by touch what is being done. For young children he gives ether, and completes the operation in one sitting.

For older patients, with tougher and more abundant growths, more than one sitting is generally required. The author also uses a ring knife, but prefers the steel nail. ED.

**CANT** (Lincoln).—**Part of Toothplate impacted in the Œsophagus, and afterwards passed naturally.** *Lancet*, No. III. Vol. II. July 17, 1886.

IT was swallowed and arrested six inches down. Coin-catchers and forceps failed to dislodge it. In little over three days it was voided naturally. It was the third part of an ordinary toothplate. ED.

**MARONE, Dr. ANTONIO.**—**Adenoma attached to the Hard Palate and Velum.** *Riforma Med.*, No. 243.

SHORT summary of the case: tumour somewhat movable and fluctuating, about the size of an egg, occupying the whole isthmus of the fauces. The operation was performed with an incandescent bistoury, and with a loop of copper wire which came away after two days. Part of the tumour fell, and the rest was removed with the scissors and Volkmann's spoon. There was no histological examination. The true nature of the neoplasm is only presumptive; the operation looks antiquated, and for many reasons is exposed to criticism. MASSEI.

**SCHECH** (Munich).—**Œsophagitis Acuta.** *Münch. Med. Woch.*, 1886. No. XLII.

IN three cases out of four seen by the author, the affection was

caused by abuse of spirits. It commences twelve or twenty-four hours after the excess. The first and most important symptom is painful deglutition; the second is pain in the œsophagus during pressure, or during flexion and extension of the vertebral column; the third is the secretion and expectoration of large masses of frothy or viscid mucus. The affection lasts from some days to four weeks. The prognosis is favourable, but abscess and phlegmon cause fatality in some cases. The diagnosis is not difficult. The application of bougies is not permissible. The treatment has to be dietetic. The food should be fluid and cold; cataplasmata should be placed on the sternum; morphia, cocaine, or tannin administered medicinally. The writer refers frequently to Morell Mackenzie's writings on this subject.

MICHAEL (Hamburg).

**GALLOZZI.**—Acute Retro-Pharyngeal Abscess. *Riforma Med.*, An. II., No. 120.

MASSEI.

**COZZOLINO, N.**—Naso-Pharyngeal Catarrh (Arthritic) with Special Swellings of the Mucosa. *Bollettino Grassi*, July, 1886.

IN this clinical memorandum, the author wishes to call the attention of his colleagues to the existence of a diathetic inflammation of the respiratory passages, and especially the form of naso-pharyngeal catarrh styled by him arthritic, an affection which the French were the first to establish, but which, according to him, the Germans are unwilling to recognize.

In the two patients to which he alluded, leathery, calcareous crusts formed in the naso-pharyngeal cavity exclusively, in the form of domed capsules, dry, and so abundant in one as to afford the author an element of proof of the specificity of the catarrh. In both the patients there was also found on the skin a chronic eczema, which the author thought should be attributed rather to a dyscrasic relation than to simple coincidence.

Thus, according to him, there should be another morbid entity, which most authors do not see the necessity of admitting, because it would not have sufficiently distinctive characteristics, and would end in multiplying morbid forms indefinitely.

MASSEI.

**WHIPHAM** (London).—On Clergyman's Sore Throat. *Lancet*, No. X. Vol. II. September 4, 1886.

THE author thinks that the affection is largely due to the habit of reading and preaching with the head bent forwards and downwards, necessitating the raising of the voice, and causing increased friction of air against the pharynx and fauces, towards which the soft palate and



faucial pillars are pressed. Hyperæmia is thus established, and if encouraged speedily becomes chronic congestion. Barristers, who, standing in the well of a court, have to raise their heads in addressing the Bench, are not subject to the same conditions, and are not, as a rule, such sufferers as clergymen. ED.

**HOLDERNESS** (Windsor).—**On Clergyman's Sore Throat.** *A Letter to The Lancet*, No. XII. Vol. II. p. 569.

THE author calls attention to the habit prevalent amongst clergymen of wearing a stiff band-like collar, which, when the head is bent, presses unduly across the thyroid cartilage. The sharp, red line on the skin shows how severe the pressure is. By discarding this collar, and wearing an open one, remedies will succeed when previously they have failed. ED.

**CASSELBERRY, W. E.**—**On Pharyngeal and Nasal Surgery by the Galvano-cautery; with Report of Cases and Exhibition of Apparatus.** *Chicago Med. Society's Proceed.*, September 20, 1886.

THE cases comprised follicular pharyngitis and naso-pharyngitis, malformation of the anterior faucial pillars, and membranous occlusion of the posterior nares.

**LUE, le Dr.**—**Contribution to the Study of Tornwaldt's Disease.** *France Médicale*, October, 1886.

THE author essays to make known the excellent results obtained in the treatment of certain cases of obstinate pharyngitis by Tornwaldt, of Dantzig; and his article appears to be less for the publication of personal work than for the promulgation of the remarkable works of Tornwaldt. After an excellent symptomatological study of inflammation of Luschka's bursa, Lue publishes observations on five patients who presented hypersecretion from the pharyngeal bursa.

The conclusions of the author are as follows:—(1) Whenever one finds a chronic pharyngitis, characterized by dryness of the pharyngeal walls, and the presence of crusts and mucus, one must look for catarrh of the gland of Luschka. (2) Energetic cauterization of the pharyngeal bursa with the galvano-cautery puts an end to catarrh of that cavity, and consequently expedites the cure of the secondary pharyngitis. (3) The co-existence of signs of true ozæna is not a contra-indication to direct intervention with the gland of Luschka. (4) Practical rhinoscopy with Voltolini's hook and the large laryngeal mirror is preferable to the usual method.

JOAL (Mont Dore).



**CHATELLIER, HENRI.**—Histological Note on Two Muriform Tumours of the Pharyngeal Extremity of the Inferior Turbinate Bodies. *Ann. Mal. Larynx*, August, 1886.

THE author gives a histological description of the tissue of these tumours—the epithelial covering, the sub-epithelial layer, the adenoid tissue, the closed follicles, the mucous tissue, and the vessels; his conclusions being that the tumours are formed of adenoid and mucous tissue, the one or the other predominating according to the portion examined. The pathological process leading to the production of these tumours is a myxomatous degeneration of the mucosa of the turbinated bodies. JOAL.

**TISSIER, P.**—Study of the Pharyngeal Bursa, or Bursa of Luschka, in its Anatomical and Pathological Aspects. *Ann. Mal. Larynx*, October, 1886.

FOUR hypotheses are emitted as to the pharyngeal bursa: 1. It is an abnormal and pathological condition; 2. It is a normal condition, being the remnant of a canal which during embryonic life unites the anterior part of the hypophysis with the anterior aditus, or with the buccal cavity; 3. It may frequently result from folding of the mucosa of the anterior aditus at the time of incurvation of the cephalic extremity of the embryo; 4. It is a normal result of the adherence of the mucosa at this point to the subjacent fibrous tissue. The author discusses these four propositions, and adopts the last hypothesis, which has been especially upheld by Ganghofner. Tissier then describes the symptoms of chronic catarrh of the pharyngeal bursa, and also of bursal cysts, and as a method of treatment recommends the employment of the galvano-cautery. JOAL.

## LARYNX.

**DE RENZI, Prof. E.**—Laryngo-Pharyngeal Tuberculosis and Syphilis (Lecture on). *Rivista Clinica e Terapeutica*.

AN interesting case with evidence of syphilis and without pulmonary lesions. A micro-chemical examination revealed in the exudation, taken directly from the larynx, the presence of the bacillus; De Renzi speaks of the possibility of cure. [Might not the bacillus be an adventitious product?] MASSEI.

**ARIZA, RAFAEL** (Madrid).—**Micosis y Tuberculosis Laringeas.**  
(**Laryngeal Mycosis and Tuberculosis.**) *Revista de Laringología,  
Otolología y Rinología.* Barcelona, October, 1886.

THE author relates the case of a patient cured of granular throat six years ago, who subsequently returned for hoarseness and dysphagia, which had lasted four months. The free edge of the epiglottis was ulcerated, and covered with a white layer; the right arytenoid cartilage tumid, polished, round, and pale; the right ventricular band enlarged throughout, and very red. Ariza diagnosed laryngeal tubercle, notwithstanding that the chest exhibited no symptom of pulmonary tuberculosis. Being of opinion that laryngeal phthisis is curable, he administered arsenical preparations, phosphate of lime, iodoform, and locally, lactic acid mixed with boracic and iodic glycerine. The laryngeal hypertrophy disappeared in two months, and the voice became normal and the disease cured, the patient recovering strength completely. But the epiglottic ulceration recurred. The author analysed the white substance covering the ulcers, and found, amongst the epithelial and purulent cells some mycelial branches. This muguet is not a special disease but develops upon appropriate soil, and becomes dangerous when it is extensive, especially when the patient is enfeebled. Ariza does not think the ulcers on the epiglottis in this case were tuberculous.

RAMON DE LA SOTA Y LASTRA.

**MAJOR, G. W.** (Montreal).—**The Submucous Injection of Lactic Acid for the Cure of the Early Stage of Laryngeal Phthisis.**  
*Montreal Medico-Chirurgical Society, October 22, 1886. (Medical News, November 13.)*

THE author regarded it as the most speedy and most efficacious plan of treatment yet introduced as a local application to the ulcerative stage of phthisis of the larynx. In the early swellings and œdemata, Krause, of Berlin, had had remarkable results, and he could confirm all that was said of it by Hering, who introduced it. Fifteen to twenty minims of a 20 to 30 per cent. solution should be inserted at one sitting. Very trifling pain followed, and ulcerations were avoided. Hering's syringe, modified by Krause, was employed.

**TUPPER, A. M.**—**Cases of Tracheotomy in Diphtheritic Croup.**  
*Boston Med. and Surg. Journ.*, vol. xcv., No. 3.

A RECORD of five cases, of which two recovered.

**WHITTAKER, J. T.** (Cincinnati, O.).—**Spasm of the Glottis in Rickets.** *Association of American Physicians, June 17, 1886.*

THE author emphasises the fact that spasm of the glottis belongs

almost exclusively to rickets, which is a curable disease, while treatment of the laryngeal affection is without effect. The spasm is often the first sign of rickets, indicating the stage rather than the degree, since it occurs mostly in cases of rapid advance of the disease. The author concludes by mentioning the inefficiency of intubation, tracheotomy, &c., and recommends douches, flagellations, electricity, &c., as the best means of combating the attack.

**LOVETT, R. W.**—*The Delayed Removal of Tracheotomy Tubes; with Cases.* *Boston Med. and Surg. Journ.*, vol. cxv., No. 3.

At the Boston City Hospital, in about three hundred tracheotomies there were only four cases in which any difficulty was experienced in dispensing with the tubes. Ordinarily the latter are removed on the fifth, sixth, or seventh day. In the first of the cases reported the difficulty appeared to be collapse of the trachea; in the second, the subject of measles and whooping-cough, the operation had to be performed a second time—no view of the larynx could be obtained; in the third case no cause for the difficulty could be ascertained; while in the fourth, where the disease was membranous croup, masses of granulations appeared to obstruct laryngeal respiration. The author remarks that sometimes spasm of the glottis appears to be excited by the passage of cold air through the disused larynx; and after discussing other possible causes of difficulty, he concludes with a few hints as to treatment.

**CASADESUS, JOSE ROQUER** (Barcelona).—*Diagnostico entre las Vegetaciones Sifiliticas y las Tuberculosas.* (Diagnosis between Syphilitic and Tuberculous Vegetations.) *Revista de Laringologia, Otologia y Rinologia.* Barcelona, October, 1886.

TUBERCULOUS growths are generally small, white, and located on the inter-arytenoid fold. Syphilitic growths are voluminous, red in colour, and grow in any part of the larynx, but especially the epiglottis.

RAMON DE LA SOTA Y LASTRA.

**ARIZA, RAFAEL** (Madrid).—*Polipos Tuberculosos de la Laringe.* (Tuberculous Growths in the Larynx.) *Revista de Medicina y Cirugia Prácticas.* September 22, 1886.

DR. ARIZA, the first laryngologist to publish a work (in 1877) relating to the polypoid and growing form of laryngeal tuberculosis, describes two cases of this nature. One was a man fifty years old, with a tumour attached by a broad base to the inter-arytenoid wall; and the other case, a young lady with several growths on the same region, and a long thin polypus which, during speaking, was concealed

beneath the vocal cords, but, during coughing, protruded between them. Both patients had indubitable pulmonary tuberculosis. The author thinks that these two cases must be classed with laryngeal tuberculous tumours, or polypi. If we did not add the adjective "tuberculous" we should remain ignorant of the true significance of the laryngeal condition. There is another species of laryngeal tuberculosis, which does not agree with the polypoid or growing form, notwithstanding its prevailing character is proliferation. This is what Ariza has merely called "hypertrophic," since there is not the singular and characteristic limitation of the tumour or polypus. Enlargements are diffuse in these cases, cover a considerable space, and are lost gradually in the neighbouring parts. This type of hypertrophy differs from tuberculous infiltration of the arytenoids and epiglottis; it is located in the mucous and submucous tissue, and its usual seats are the ventricular bands and the inter-arytenoid space; in colour, it is deep red, with some whitish spots. Tubercular polypi are characterized, according to Ariza, by—1st, greyish and whitish spots, indicative of the epithelial destruction; 2ndly, by the facility with which they ulcerate, on the slightest traumatic or caustic action; 3rdly, by their softness and yielding nature; 4thly, they are generally single.

RAMON DE LA SOTA Y LASTRA.

**ABDUCTOR PARALYSIS.**—*Lancet*, June 5, 1886, p. 1077.

IN a leading article we notice the following remarks: "Dr. Felix Semon's anatomical and clinical proof, established by a large series of observations, that the abductors are more prone to paralysis than the adductors, is really of the same order as Dr. Ferrier's generalization (that the abductors and extensors are generally weaker than the adductors and flexors). . . . the great truth to be recognized is that muscles of antagonistic action are not endowed with equal strength. This difference in strength shows itself in a greater proclivity to paralysis, as well as in a less ready power of recuperation . . . . Whilst admitting that there is a great difference in the strength of the antagonistic apparatus, Dr. Gowers has brought forward a strong argument tending to show that a mechanical explanation would go far towards interpreting the reason why adduction is more powerful than abduction: 'A force acts on a lever at greatest advantage when applied at right angles to the lever.' The mechanical advantage at which the chief adductor acts, as compared with the chief abductor, gives greater power to the former, since it passes at nearly right angles, whilst the abductor passes at a very acute angle, to their identical insertion into the muscular process

at the outer angle of the base of the arytenoid cartilage. This mechanical consideration may afford, at least, some explanation of the effect of a general under-action of the recurrent nerve in impairing 'the effect of the abductors, more than that of the adductors, just as the general over-action on electrical stimulation increases the effect of the adductors out of proportion to that of the abductors.' In some cases of slowly progressive paralysis it has been observed that, notwithstanding a final total palsy, the vocal cords have been nearer together than in the cadaveric position. This has been explained by assuming that secondary contracture, having lasted a long time, had given rise to fibrotic processes, which had set the adductors in a fixed position, much as happens in the permanent rigidity of cases of hemiplegia and infantile palsy." ED.

**KRAUSE** (Berlin).—**Aphonia et Dyspnœa (Laryngo-) Spastica.**  
*Berlin. Klin. Woch.*, 1886, No. 34.

UNDER the above title we described, last year, a case in which the juxtaposition of the ligamenta vocalia, causing spastic aphonia and dyspnœa, was overcome by chloroform-narcosis. After recovery from the narcosis, the *status quo ante* returned, and tracheotomy was performed. The case proves that there was no abductor paralysis, but spasm of the adductor muscles. The affection remained uncured. Krause has seen a similar case. A patient with symptoms of spinal sclerosis had aphonia spastica and dyspnœa. The laryngoscope revealed juxtaposition of the ligamenta vocalia. The patient was cured by local applications of cocaine for fourteen days.

The author draws the conclusion that, in all cases of juxtaposition of the vocal ligaments, spasm is the first event, and paralysis may follow from fatty degeneration of the abductor muscles. We do not agree with this, since in many of these cases tracheotomy is performed during narcosis; but never during narcosis had the symptoms disappeared. This must have occurred if there had been a spasm. That it was not so proves that in the other cases there was paralysis.

MICHAEL (Hamburg).

**DESVERNINE.**—**De la Contraccion Paradoxal de Westphal en laryngo-dinámica.** (On the Paradoxical Contraction of Westphal in laryngo-dynamics.) *Habana: Imprenta de Alvarez*, 1886.

THE author refers to a former work, in which he explained the mechanism of the antero-posterior tension of the vocal cords. The suprahyoid muscles drawing up the thyroid cartilage, fix it, and allow the crico-thyroids (on which depends the elongation of the



vocal cords) to contract, serving as a fixed point for their thyroid insertions. Desvernine calls this functional act, "active immobility of the thyroid cartilage," and "passive immobility," the ascent and fixation which are mechanically imparted to it when the tongue is protruded from the mouth. This explanation of the causation of tension of the vocal cords, according to which the thyroid does not descend upon the cricoid, but the latter ascends upon the thyroid, allows the author to explain the instantaneous reappearance of the voice in some aphonic patients having paresis of the crico-thyroid muscles, and who frequently emit a note when under laryngoscopic examination.

Desvernine thinks with some laryngologists, that the reappearance of the voice is often due to a subjective psychical impression generated by the laryngoscopic examination. This does not explain all cases. There are some in whom drawing out the tongue, without the use of the mirror, suffices to restore the voice; and others in which the efforts must reach a certain point to re-establish mobility and with it, phonation. Desvernine thinks Westphal's paradoxical contraction explains this. The protrusion of the tongue causes elongation of the infrahyoid muscles antagonistic to the suprahyoid, which latter are defective in this form of paralysis. This is how restoration of the voice occurs frequently during laryngoscopic examination. Desvernine having observed the same phenomenon in adductor paralysis, applies to these cases the term "paradoxical contraction." He adopts the method originated by Kolliker in the treatment of adductor paralysis, viz., bilateral compression of the thyroid wings during an effort at vocalization.

Desvernine explains by schema the function the valvules perform (made by the bands in expiration) in respect to the cords. By forced adduction, in compressing the lateral plates of the thyroid cartilage, the posterior crico-arytenoid muscles are relaxed, a reflex action appears in their antagonists—the crico-arytenoidei laterales,—and these, which are the paralysed ones, contract temporarily or permanently, with sudden disappearance of the aphonia.

RAMON DE LA SOTA Y LASTRA.

**MEINHARD SCHMIDT** (Cuxhaven).—**Congenitale Tracheal stenose durch Abnorme der Tracheal Knorpel.** (Congenital Tracheal Stenosis, caused by an unusual Curvation of the Tracheal Cartilages.) *Deutsche Med. Wochenschr.*, 1886, No. XL.

A CHILD of one and a half had stridor and dyspnoea of congenital origin. Tracheotomy was performed without success. The dyspnoea



remained, and the child died on the day of the operation. The trachea was compressed, the rings, no longer round, but flattened as far as the bifurcation of the right bronchus, like a sabre-scabard, just as it is sometimes found in cases of struma. No cause was discovered for this compression. MICHAEL (Hamburg).

**HOPE, G. B.—A Modified Operation in Laryngeal Stenosis from Paralysis.** *New York Medical Journal*, November 20, 1886.

THE author suggests, instead of tracheotomy, that thyreotomy be performed, and removal of so much of the paralysed cord as obstructs respiration; but he has as yet had no opportunity of applying the operation practically.

**BUTT (Calcutta).—Dislocation of Cricoid Cartilage.** *Lancet*, No. III. Vol. II. July 17, 1886.

A LADY suffering sea-sickness, lying in her berth, on turning her head, experienced suffocating pain in her throat and gasped for breath. In the middle line in front, the lower margin of thyroid was unduly prominent, and under its left margin, the left margin of cricoid could be felt tilted up. Manipulation of the cricoid, with rotation of the head to the opposite side, replaced the cartilage. ED.

**NEWMAN, DAVID.—Excision of the Larynx for Malignant Disease.** *Lancet*, No. IV. Vol. II. July 24, 1886.

THE disease was carcinoma: six months afterwards there was no recurrence. The disease was strictly limited to the larynx. For details, see the original. ED.

## NECK, &c.

**DWIGHT, THOMAS.—The Relations of the Inferior Thyroid Artery and the Recurrent Laryngeal Nerve.** *Boston Med. and Surg. Journ.*, Vol. CXV., No. 8.

AFTER pointing out the interest of the subject in cesophagotomy, but more especially in removal of the thyroid, the author refers to discrepancies in the statements of various authorities, Wöfler having asserted that the nerve passed always before a branch of the artery, while Kocher describes the artery as passing behind the nerve, coming forward on its inner side, and hooking over it. Of fifty-two bodies examined by the author, the arrangement was symmetrical in twenty-nine. Of these, the artery was before the nerve in twenty-one,

and behind it in eight. Taking all the bodies together, on the right, the artery was before the nerve thirty-three times, and behind it thirty-one; on the left, the artery was before the nerve forty-nine times, and behind it fifteen. The author concludes by observing that the practical deduction appears to be, that when it is necessary to tie the artery near the gland it should be carefully isolated, and that if the base of an enlarged thyroid be transfixed and ligatured *en masse*, it is evident that if the nerve should happen to pass before the artery it would be in danger of being included.

**GORDON, JAMES.**—Myxœdema following upon Removal of the Thyroid Gland. *Lancet*, No. II. Vol. II. July 10, 1886.

ELEVEN years ago a goître was extirpated by Professor Lister. It had then existed six years. The woman returned home at the end of three months, with her face and voice altered. The face was pasty and waxy, the lips thick and swollen, speech embarrassed, slow, and nasal. There were weakness, feebleness in walking, scanty urine without albumen. The heart sounds were feeble. The mother did not know her daughter, her face and voice being so altered. At no time was there any renal or cardiac trouble. At the end of six months she was markedly myxœdemic. After a long lapse of time marked amelioration occurred. There was less anæmia, less œdema, the hair grew again, and speech improved. The patient remains, however, a wreck. The case is considered to be one of "cachexia strumipriva," as described by Kocher of Berne, or what in this country is called "myxœdema." The age of the patient was forty-two, and the disease is not restricted, therefore, to the growing age. The author discusses the pathology of the affection in his paper. ED.

**SLOAN, A. T.** (Edinburgh).—Is Goître Hereditary? *British Medical Journal*, November 6, 1886.

OF twelve cases collected by the author at Wishaw, Lanarkshire, eight show distinct heredity; in six both mother and grandmother had had goître; in one the mother died from exophthalmic goître; in the other, a cousin had goître. Of eighteen cases collected at Penrith, Cumberland, ten are distinctly hereditary; in eight the mother, and in two the father, suffering from goître.

Five cases instance the occurrence of goître in the sisters belonging to the same family, though some of these had lived for long in different parts of the country.

The disease is not only hereditary, but may be congenital. In one of the author's cases it was so, and recently he has had notes sent to

him of two cases of congenital bronchocele, when the mother also was affected. Keiller records such a case, James Reid saw three, and Faderi records three such congenital cases. Godelle, of Soissons, also records a case. Bramley says that in India both children and animals are born with it; and cases of congenital goitre have been recorded in Derbyshire. The author thinks that these facts go to prove that goitre is really a hereditary disease. Ed.

**SLOAN, A. T.** (Edinburgh).—**The Relation of Goitre to Menstruation and Pregnancy, and the Influence of the Sympathetic Nervous System in its production.** *Edin. Med. Journal*, September, 1886.

THIS paper was read before the Medico-Chirurgical Society of Edinburgh, 5th May, 1886. The author states that the mere fact that goitre occurs much more commonly in women than in men would lead us to suspect that an intimate relation exists between the thyroid gland and the female generative organs. In his experience he has found that enlargement of the thyroid seems associated with an early rather than with a delayed onset of menstruation. He believes that it is occasionally associated with diseased uterine functions, and not unfrequently disappears on the organ regaining its healthy action. Pregnancy appears to determine its commencement, or cause its increase. In regard to the sympathetic system, he thinks that the influence exerted by the generative organs is, most probably, through the medium of the branches of the middle and inferior cervical ganglia which supply the gland.

In the discussion which followed, Dr. Ireland thought the weak point in the author's theory consisted in the assertion that goitre commenced about the age of puberty, whereas it was known that not only were children affected with it, but also might be born with it. In his reply Dr. Sloan allowed that in India and Switzerland men were commonly affected with goitre, but in other places women were most affected.

HUNTER MACKENZIE.

**W. HALE WHITE.**—**On the Prognosis of Secondary Symptoms and Conditions of Exophthalmic Goitre.** *Brit. Med. Jour.*, July 24, 1886.

OF twelve cases traced by the author, seven died; two suddenly, no obvious cause being found *post mortem*; one from mitral regurgitation; one from axillary abscess; one from gastric ulcer; one from consumption; in the seventh the cause of death was unascertainable. The average duration of life after first appearance of symptoms was

three and two-third years. The best treatment appeared to be galvanism and iced water. Three of the four cases who died in hospital, showed some affection of the lymphatic system. In one the thymus was persistent, and Peyer's patches particularly well marked; in the second, the thymus was swollen as well as Peyer's patches; in the third, Peyer's patches were of a dark livid colour. Among the five living cases, not one shows any sign of myxœdema or thyroid atrophy.

G. MACDONALD.

**MIDDLETON** (Glasgow).—**Salivary Calculus.** *British Medical Journal*, October, 1886. Exhibition of Specimens, spontaneously discharged, before the Glasgow Pathological and Clinical Society.

HUNTER MACKENZIE.

**KEITH, SKENE** (Edinburgh).—**A Case of Suppuration of the Parotid, following Ovariectomy.** *Edinburgh Medical Journal*, October, 1886.

THE title indicates the nature of the case.—HUNTER MACKENZIE.

**JALLAND** (York).—**Parotitis following Ovariectomy.** *Lancet*, No. XX. Vol. II. November 13, 1886.

THE disease was not contracted from any external source. Three days after operation for ovariectomy, swelling of the right parotid occurred, and six days after, the same condition of the left side. The patient recovered speedily.

ED.

**MICKULICZ** (Krakau).—**Zur Operativen Behandlung des Empyems der Highmorshöhle. (Operative Treatment of Empyema of the Antrum of Highmore.)** *Zeits. f. Heilk.*, Bd. VII. p. 261.

THE author has invented a short stylet-formed knife on a curved handle. He can, with this instrument, perforate the lateral wall of the antrum. If violent bleeding ensue, the nose must be closed by a tampon of iodoform for one day. The antrum is then cleansed by injections, which must be continued till suppuration ceases. Success has attended this method in four cases.

MICHAEL (Hamburg).

**STOERK.**—**Ueber die Lokale Behandlung des Empyems der Highmorshöhle.** *Separatabdruck aus Dr. Wittelshöfer's "Wiener Med. Wochenschrift,"* No. 43, 1886.

MIKULICZ, of Cracow, having communicated a new mode of operating for empyema of Highmore's cavity to the Congress of German Surgeons, Stoerk recalls the methods adopted by himself for a long time. There are constantly found apertures, in the form of long oblique slits in the antrum, at the upper and fore-end



of the middle turbinated bone, and, according to Henle, about the centre of the mid-nasal channel there is an entrance to the antrum. The inspection of these apertures is difficult. Since the publication of his book, Stoerk has several times had the opportunity of observing empyema of the antrum of Highmore. It is mostly associated with intense pain in the fossa canina, and neuralgia of the upper jaw. As a great aid in diagnosis is the "parallel verlaufende dilatationsspiegel," and further, compression of the mucous membrane by tampons. Great dilatation can be obtained by tampons of strongly compressed wadding; and by pressing out the contents of the succulent mucous membrane, a good view of the mid-nasal channel can be obtained. Often, also, one can see the entrance into the antrum as a purulent spot, due to discharge of the pus outwards. Spontaneous cessation of pain occurs from the discharge of the secretion in this manner. Stoerk has often treated this condition successfully by using a syringe, ending in a short fine tube, and which he can introduce into the antrum. This method, though certainly not easy, is preferable to other operative interference. The method of removing a tooth to permit of discharge has many disadvantages. The discharge into the mouth causes nausea. Stoerk thinks the disease is seldom spontaneous, but is propagated from the inflamed nasal mucosa. When the swelling of the nasal mucosa is so great that it is difficult to insert the bent end of a syringe, Stoerk has used a still simpler method. This consists in affixing to a larger syringe a fine tube of caoutchouc, with the fore-end closed, and a small aperture on the side. This he introduces into the nasal cavity as far as the hole. The patient can tell with great accuracy when he feels the pressure of water in Highmore's antrum, and this is sufficient to enable the operator in future always to find the spot accurately. It is only necessary to measure from the opening in the side of the tube how far it had to be introduced, and to make a mark. Outside the tube a mark must also be made, to indicate on which side the aperture is.

All medicaments must be applied as warm as possible. Very concentrated solutions cause severe reaction, and weak solutions are to be preferred—1 to 2 % argent. nit., salicylate of soda, salt, tannin, and exceptionally, zinc. Wad tampons are of the greatest service. These, rolled round a knitting needle, can be moulded into bougies. Zinc paste may be spread on them, and introduced into the nose.

Ed.

## REPORTS OF SOCIETIES.

### Clinical Society of London.

At a meeting held on October 8, 1886,

Mr. PEARCE GOULD exhibited "*A Case of Undeveloped Sexual Organs associated with Congenital Defect of the Tonsils*," and read notes respecting it to the meeting. The patient was twenty-seven years of age, over six feet high, slender, with fair, soft, smooth face, a boy's voice, and no hair on his face. The penis was small, the testicles were both quite small, but the right epididymis was thickened, which Mr. Gould attributed to a blow on the part when the boy was eleven years of age. The prostate could scarcely be felt through the rectum, and the seminal vesicles could not be felt. The man had no sexual desire; the only sign of any sexual activity was occasional slight priapism. There was an oblique inguinal hernia on the right side. The pillars of the fauces were close together, and only very small tonsils could be seen or felt between them. Mr. Gould said the case raised the question whether there was any intimate connection between the tonsils and the testicles. It was a popular notion that excision of the tonsils before puberty endangered virility, and Dr. Shorthouse, quoted by Dr. Ogle, was named as a writer who spoke of such an effect as a matter of common observation. The shrinking of enlarged tonsils, and the cessation of repeated attacks of tonsillitis at puberty, were adduced in support of the influence of sexual maturity upon these organs. On the other hand, in Zanzibar, where all boys have their tonsils excised, the testicles were well developed, and the operation now was so common that, were it liable to be followed by such a grave result as non-development of the sexual organs, abundant evidence of this fact would be forthcoming. The removal of an enlarged organ was different from its imperfect development, and might be attended with different results. Mr. Gould had seen two women with absent or undeveloped ovaries, and in whom the tonsils were of full size; and Dr. Langdon Down, who had seen many cases of imperfect sexual development, had not observed any associated change in the tonsils.

The PRESIDENT (Mr. Bryant) and other speakers, expressed the opinion that there was nothing to support the view that there is any real connection between atrophy of the sexual organs and atrophy of the tonsils.

### Manchester Pathological Society.

At the annual meeting of this Society, held on October 13, 1886,

Dr. DRESCHFELD exhibited *A section of tissue from Rhino-scleroma*. The section (for which he was indebted to Dr. Payne, of London) showed the presence of numerous bacilli occurring in small masses in the midst of the tissue. These bacilli were smaller than the tubercle bacilli, less slender, and the extremities slightly thickened. These micro-organisms were unlike those shown recently at the Berlin Medical Congress by Paltanuf, who describes the organism as similar, if not identical with, Friedländer's pneumonococcus, and who obtained pure cultivations which, as regards their form of cultivation, their microscopic appearance, and their behaviour when injected into mice, resembled the pneumonococcus.

Dr. HODGKINSON showed several small *Papillomatous Growths from the Larynx* coughed up at short intervals by a woman aged forty. When first seen, fourteen months ago, she was suffering from complete aphonia and dyspnoea. Laryngoscopic examination revealed the presence of three growths. Marked improvement resulted from repeated applications of the galvano-cautery, and the patient ceased to attend. After an absence of four months she was admitted into the Throat Hospital at Bowdon with such urgent symptoms that tracheotomy was performed by Mr. Hardie. Dr. Hodgkinson called attention to a point of great



interest—viz., the steady diminution in the size of the growths under the influence of the physiological rest since the operation. Microscopically, the growths were of a simple character.

### Midland Medical Society.

At a meeting held on November 10, 1886,

Dr. SUCKLING showed a man, aged forty, suffering from *Myxœdema*. He had been ailing for two years, complaining of debility and *malaise*. He presented the usual symptoms of myxœdema in a typical manner. The urine was free from albumen, of low specific gravity, and deficient in urea. There was no reduplication of the heart-sounds, but feebleness of the circulation was a marked feature, the extremities always being cold, and the pulse small and of low tension. The temperature was 97·5 Fahr.

### British Medical Association: Metropolitan Counties Branch.

At a meeting held on November 18, 1886,

Dr. ORD made a series of clinical remarks pointing out the typical and most prominent features of *Myxœdema*, and demonstrating the various points in his own and other patients. He believed that sporadic cretinism was but myxœdema beginning in early life before development was complete. He was afraid that treatment was of little value, but urged the necessity of warmth, recommending that, if possible, such patients should spend the winter abroad. He had found some benefit from the use of pilocarpine and jaborandi.

Mr. VICTOR HORSLEY gave an account of the surgical history and pathology of myxœdema, especially as connected with Kocher's experiments, and the removal of the thyroid. He referred to his own experiments on monkeys, in whom removal of the thyroid, carefully performed, without injury to surrounding nerves, was followed by all the symptoms typical of myxœdema. He considered it proved that the thyroid was connected with the metamorphosis of connective tissue. He referred to the ignorance displayed on the Continent of the work done in this field of inquiry by Englishmen.

Dr. HADDEN made a few remarks, stating that he had given up the idea which he first put forth that this disease originated in the cervical sympathetic, since he had met with two cases in which, *post mortem*, the sympathetic was found to be normal and the thyroid diseased.

*Microscopical specimens* were shown by Mr. VICTOR HORSLEY. The following living specimens were exhibited:—1. By Mr. VICTOR HORSLEY: Two well-marked cases of Sporadic Cretinism, both males, aged respectively 22 and 29. 2. By Dr. AMAND ROUTH: A woman suffering from Myxœdema, and a case of Cretinism in a female aged 22. 3. By Mr. SAUNDERS: A case of Myxœdema in a man. 4. By Dr. SANSOM: A case of Myxœdema in a woman.—*British Medical Journal*, November 27.

## ASSOCIATION AND CONGRESS MEETINGS.

### Report of the Annual Meeting of the British Medical Association, Brighton, August, 1886.

THE following papers were read in the Otological Section:

1. WOLSTON, W. T. P. (Edinburgh).—“*Nasal Polypi: their Radical Extirpation and Cure by Electro-Cautery; with Illustrative Cases.*”

Mucous polypi are most frequent, and evulsion has been for long the principal treatment. Other methods, used without sufficient illumination of the nose, are

condemned by the author as painful and inefficient to avoid recurrence. The author cannot agree with Zaufal as to the preference of the cold snare, and praises the electric cautery as the most perfect method of treatment. It is not true that it is tedious, since in one case the author removed ninety separate polypi within fourteen days—forty-two at one sitting; and in another, he removed thirty-two polypi in less than an hour.

The author lays great stress on perfect illumination, using v. Brun's oxy-hydrogen limelight, and Voltolini's modified Charrière's dilating speculum for anterior, and Michel's post-rhinal mirror with lever spring, for posterior, rhinoscopy. Accumulators supply battery power, Michel's handle and tubes for the wire loop, and v. Brun's handle and cautery are used by the author. Iron wire is preferable to platinum. The polyp is secured by the snare, the latter tightened, and the current passed intermittently. A few seconds suffices to remove the polyp mass, without hæmorrhage, or much pain, pulling, or tugging. Whereas deaths have occurred from avulsion, no ill results follow this method. Intervals of two or three weeks are allowed between each sitting. Cauterization of all suspicious-looking tissue in the nares, after removal of all polypi, is strongly urged. Pain, easily borne now, is more acute as the mucous membrane becomes healthy, and cocaine must then be used. The progress of the case towards recovery is in inverse ratio of the patient's ability to bear the cautery.

The author cautions the operator against believing the statements of the patients that they are quite cured, and presses the necessity of occasional examination afterwards to check any fresh development. The author thinks the time not far distant when surgeons will discard older and clumsier methods in favour of the electro-cautery.

A table of thirty-four cases follows, of great interest.

In one case the author removed ninety, in another eighty-three, and in two cases seventy-six nasal polyps. In all his cases, the breathway, which was obstructed, smell and taste, which were impaired or lost, were restored to the patient; and the author is much to be congratulated on his success.

2. SEMON AND HORSLEY.—“*On an Apparently Peripheral and Differential Action of Ether upon the Laryngeal Muscles.*” (A Report to the Scientific Grants Committee of the British Medical Association.)

The authors refer to Hooper's work, in which he found that stimulation of the recurrent laryngeal nerve, either when cut and the peripheral end stimulated, or when the intact nerve was stimulated, in dogs, under the influence of ether, was followed by abduction of the vocal cord; while, when recovering from the influence of the ether, stimulation of the recurrent laryngeal caused adduction. Semon and Horsley remark that this would seem to point to a hitherto unsuspected local action of a general anæsthetic agent, such as ether, since anæsthetics only affect the muscles of organic life—under which head come the posterior crico-arytenoidei—when given in huge or lethal doses. If abduction occurs when the *cut* recurrent laryngeal is stimulated in a narcotized animal, it follows that there must be some action upon the nerve-fibres, the endings in the adductors, or muscle itself, provided no ganglionic apparatus exist in the larynx, of which at present there is no evidence. Semon and Horsley refer to the dogma, that in all cases of coarse disease of the recurrences, either nuclei or trunks, the *abductor* fibres first suffer, while in functional disorders the *adductors* are first affected. The authors combat Krause's views, founded on experiment, as to the nutritive changes observed in the posterior crico-arytenoidei after tying corks to the recurrent laryngeal, and which he regarded as due to “mechanical immobilization” of this muscle, and agree with the opinions of Fränkel and Rosenbach, that such

changes are not known to exist in consequence of mere "mechanical immobilization" of from two to five days' duration, as in Krause's experiments. The authors refer to Grützner's and Simanowsky's histological experiments, that the abductors belong to Krause's and Ranvier's red muscles, the adductors to the white muscles. The authors lay great stress upon observations which show that in all animals (monkeys, dogs, cats, rabbits), if the larynx be excised immediately after death, the posterior crico-arytenoidei lose their electrical excitability long before the adductors. The extensor body muscles, to which the abductor apparatus is likened, also lose their excitability post mortem sooner than the flexors. Jeanselme and Lermoyez have shown that in cholera patients the abductors die first. The authors have performed thirty-two experiments on the cut and uncut recurrent laryngeals, in twenty animals (three monkeys, eight dogs, five cats, four rabbits); twenty were performed on the uncut, and twelve on the cut nerve. The experiments on dogs were very constant, and confirm Hooper; and whether the nerve was cut or uncut, all results, further, were obtained with a current of 15 cm. Their results only harmonize with Donaldson's when the animal was not deeply narcotized. Deep narcosis is necessary to obtain Hooper's results, and Donaldson's results differ because he did not push narcosis far enough. With slight narcosis, the authors obtained Donaldson's results; with deep, Hooper's. The authors conclude by referring to the series of popular fallacies surrounding such an investigation. Abduction followed stimulation of the recurrent, cut or uncut, in cats, whatever the degree of narcosis; again, in the same class of animals, abduction is sometimes more easily obtained, at other times adduction; age plays a not unimportant part, in young animals abduction prevailing; the prolongation of an experiment produces complications; again, it is very difficult frequently to classify the condition, as abduction or adduction. The possibility of the spread of the current, the strength of the current, the depth of narcosis, complicate the conclusions.

3. DONALDSON, FRANK (Baltimore). — "*The Function of the Recurrent Laryngeal Nerve.*"

Dr. F. Donaldson has endeavoured to test Dr. Hooper's conclusions, that the constrictors cease to act during profound narcosis, and that under these conditions the posterior crico-arytenoid produced dilatation of the larynx under stimulation. In the first five experiments on dogs, with induction strength of ten, abduction was invariably produced under profound anaesthesia. The same happened under slight etherisation. In no case did he obtain abduction. In a sixth experiment, with the same strength of current, the same result, whether deep or slight etherisation. Afterwards, in the same animal, with the induction current weakened to eighteen, he obtained abduction of the vocal cords; with a stronger current (ten), again adduction. In every experiment he found, with strong stimulation, adduction, with weak stimulation, abduction. His experiments showed (1) that the constrictor muscles did not cease to act during narcosis, however profound, or during suspension of consciousness from any cause; (2) that abduction obtained by Hooper was in no way reflex; (3) that abduction invariably occurs with weak stimulation, whether the animal be eupnoëic or apnoëic, when the medulla was destroyed and after local death. Neither Hooper nor Donaldson found any evidence that the abductor fibres were more prone to disease or more vulnerable than the adductor fibres, as is insisted upon by Semon.

4. STOKES, Sir W. — "*Acute Myxœdema following Thyroidectomy.*"

This paper was a record of three cases of thyroidectomy—the first showing how rapidly symptoms of myxœdema may be developed after a complete thyroidectomy; the second showing that a partial removal of the enlarged gland may be followed by a shrinking and disappearance of the remainder of the enlarge-

ment; and the third strengthening the view that the same results, in certain selected cases, may be obtained by the comparatively simple operation of division of the isthmus. The first case was a girl of eighteen, with great enlargement of both lobes, and suffering from dyspnoea. The left lobe was removed first, on the lines laid down by Kocher, under strict antiseptic precautions. Hæmorrhage was almost uncontrollable, and the patient greatly collapsed. The subsequent progress was satisfactory, and the right lobe diminished somewhat in size. But in the course of six weeks it was as large as, or larger than, before, and the strong thrill and dyspnoea were present in an intensified form. Ten weeks after the first operation the right lobe was removed, the hæmorrhage being even worse than on the former occasion. Yet the case progressed favourably until the eleventh day, when she complained of dull aching in her legs and knees. Next day she had an epileptiform seizure. Then there was observed swelling about the eyelids, wrists, and feet, and there was evident mental torpidity. These symptoms increased, œdema of the lungs set in, and the patient died on the nineteenth day from the operation.

5. MACDONALD, GREVILLE.—“*On the Functions of the Nose.*”

The author, after stating that his observations were mainly drawn from pathological conditions, first invited attention to the condition called *pharyngitis sicca*, usually described as a symptom of granular or atrophic pharyngitis, but which he affirmed to be generally associated with swelling of the middle turbinated bodies, and obstruction in the middle and superior meatus; and he held that the symptom was due to the inspired air, unmoistened in the upper channels, impinging on the posterior wall of the pharynx in an abnormally dry condition, and so abstracting its moisture. The glazed condition was invariably found to be due to a film of dried mucus which might be wiped off. He then referred to a physiognomy peculiar to persons long the sufferers from obstruction in the upper channels, whether from polyp or hypertrophied mucous membrane, which he believed was due to persistent shortening of the *levator labii superioris alaeque nasi*, the purpose of the shortening being to bring the alæ more on a level with the inferior meatus, and so to facilitate the passage of air directly backwards. He asserted that the physiological movements connected with olfaction supported this theory. In the course of his remarks he took exception to the practice of ablation of portions of the middle turbinated bone, affirming that every good could be attained by less severe measures.

6. BABER, E. C.—“*On Examination of the Nasal Cavities from the Front.*”

In this paper, which was illustrated by diagrams of anterior rhinoscopic views, the author described the different appearances seen on examining the nasal cavities from the front, first in the collapsed, and secondly in the erected state of the inferior turbinated body. He drew attention to the tubercle of the septum as it appears in the living subject, and to the different modes in which it hides the middle turbinated body, and, in addition to other details, mentioned the importance of cocaine in assisting an inspection of the deeper parts, by its contracting effect on the inferior turbinated bodies. The author, in conclusion, urged the value of the practice he followed of making sketches of the anterior rhinoscopic view for recording cases. During the meeting a demonstration of cases illustrating points mentioned in the paper was given by Mr. Baber at the Throat and Ear Dispensary.

ED.



**Report of the Laryngological Subsection of the 59th Meeting of German Naturalists and Physicians. Berlin, September, 1886.**

FIRST MEETING, 18TH SEPTEMBER.

President, Herr Fränkel. Secretaries, Herr Krause, Herr Landgraf.  
Arrangement of times and election of presidents.

SECOND MEETING, 20TH SEPTEMBER.

President, Herr Fränkel.

EXNER (Vienna) demonstrated on a rabbit the "*Innervation of the Larynx*." By alternately stimulating the sup. laryngeal and median laryngeal nerves, the crico-thyroid muscle of the same side is seen to contract strongly.

Exner also showed some anatomical preparations, demonstrating the median laryngeal nerve in various animals. In some microscopical specimens from the larynx of a child, he showed the entrance of this nerve into the crico-thyroid muscle, and the perforation of some of its branches through the ligamentum conicum, &c.

GERHARDT asked in what manner animals died, in which the median laryngeal nerves had been cut?

To this EXNER replied that the animals refused food, and died after some days without any special pathological phenomena.

KRAUSE asked what relation the superior laryng. nerve had to the functions of swallowing and phonation?

EXNER replied that it was impossible to say with certainty.

A paper was read by SEMON (London), "*On Paralysis of Abductors not Contraction of Adductors*."

The author referred only to experimental labours, and to pure paralysis of the abductors. He cites his experiments, in which he found: 1. That in an animal recently killed, the posterior crico-arytenoid muscles first lose their electrical excitability. 2. If a thread, dipped in chromic acid, is laid on one of the recurrens, the crico-aryten. posticus was always the first to be paralysed. 3. He could not confirm, for man, the assertion of Krause, that during rigor mortis the glottis is closed in its whole length. The expression cadaveric position should not be used, as this position is not constant. He then directs attention to the causes of error. 1. The results differ in different classes of animals. 2. Individual differences exist in the same class of animal. 3. The age of the animals. 4. The duration of the experiment. 5. The difficulty of hindering the passage of the current on to the vagus and superior laryngeal. 6. There are often complex positions, which cannot be designated simple abduction or adduction. 7. The strength of the current (Donaldson) and degree of narcosis (Hooper) are not to be disregarded. As to Krause's experiments, he concedes that there is irritation, but not contraction, because—1. It is not permissible to declare the result of the experiment with conventional clinical definition. 2. A tonic spasm of the glottis is conceded by other authors. 3. He would ask what would have been the results if Krause had experimented unilaterally?

The process *intra vitam* is a chronic one, and it is possible that by-and-bye a destruction supervenes without any pressure. In experiment the process is rapid. It might be that during chronic destruction of the nerve, if the posticus be already impotent, sudden irritations in the adductors may occur. He believes he has shown that paralysis of the postici explains the phenomena, and clinical and pathologico-anatomical reasons support this. It might be conceded that in some acute cases there might be symptoms of irritation, but in the greatest number we must conclude that it is paralysis.

KRAUSE declared that the results of post-mortem examination, which showed



atrophy of the postici in immobility of the vocal cords, proved nothing. A thread drawn through the recurrent does not perforate the nerve, but only the neurilemma. The loss of contractility of the postici, said to result, must be an error. Experiments must be made *intra vitam*, and not *post mortem*.

MESCHÉDE (Königsberg) had successfully treated a case of posticus paralysis with strychnine. That would not be possible if there had been a contraction.

E. FRÄNKEL (Hamburg) confirmed Semon's communication as to the cadaveric position.

REMAK (Berlin): Only clinical and pathologico-anatomical experiments can decide the question. If the laryngeal nerves are of the same nature as all other nerves, a tonic contraction of the adductors is only possible if of reflex origin.

B. FRÄNKEL (Berlin) remarks that it is possible to differentiate paralysis from contraction by the degree of tension of the vocal ligaments.

REICHERT (Rostock) referred to a case of median position of the vocal cords, in which he had used cocaine with success.

HEYMANN (Berlin) referred to a case of "railway spine," with aphonia spastica. For one day there was also spastic dyspnoea.

SCHMIDT (Frankfurt) suggested the use of German words for "adduction" and "abduction."

SEMON replied, that the experiments of himself and Horsley must be repeated by others. If it is proved that in other nerves, under the same conditions, neuro-pathic contractions follow, he will declare himself convinced, but not till then.

A paper was read by STOERK (Vienna), "*On the Treatment of Empyema of the Antrum of Highmore*" (referred to elsewhere).

TORNWALDT (Danzig): This condition is not so rare, and may exist without the symptoms of chronic suppuration.

GUYE (Amsterdam) has adopted Ziem's method of perforating the antrum in some cases of ozena with good results. He thinks a counter-opening, enabling one to clean the antrum, is better than the method of Stoerk.

BAYER (Brussels) recommends dilation of the natural orifice by the galvano-cautery, and afterwards placing the patient on the abdomen, with head hanging down, so as to empty the antrum. He has had very good results thus.

SCHLESINGER (Dresden) also prefers a large opening, and has had good results in acute suppuration. In cases of ozena he has not had any success.

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#### THIRD MEETING, 21ST SEPTEMBER.

President, v. Schrötter.

The PRESIDENT showed his first assistant, Dr. Karis, who had been infected during the performance of tracheotomy on a diphtheritic child. Two days after the operation Dr. Karis had coryza and fever; the next day the body was covered with hæmorrhagic pustules, which became ulcers. Membranes then appeared in the pharynx and larynx, with great dysphagia and collapse. For three weeks the œsophageal tube was necessary, in order to feed the patient. The treatment adopted was ol. tereb., aq. calcis, and quinine internally. During convalescence fresh intumescence of the posterior wall of the larynx occurred with laryngeal ulceration and dyspnoea, which increased. On the return to Vienna from Italy, where the patient had been for some months, Dr. Karis had stenosis, in consequence of the growing together of the vocal cords. This was cut through, and the larynx treated with laryngeal tubes, which must still be continued.

B. FRÄNKEL and STOERK believed there had been metastatical abscess from direct infection of the blood with diphtheria.

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A paper was read by STRÜBING (Greifswald), "*On a Rare Form of Laryngeal Edema.*"

There is a form of edema laryngis, along with edema pharyngis and edema cutis, caused by angioneurosis. Beginning with hyperemia, there quickly follows an intense edema; albuminuria does not occur. One patient had attacks of vomiting, as in tabetic gastric crises. Perhaps this is a neurosis of the vasodilators.

A paper was read by REICHERT, "*On the Treatment of Chronic Tracheitis and Bronchitis.*"

He applies inhalations of medicated fluids, *e.g.*, oil of eucalyptus, ol. menth. pip., tannic acid, &c. For chronic tracheitis he applies these medicaments by a special syringe of his own invention.

SCHNITZLER, SCHLESINGER, and TOBOLD question the methods of Reichert.

KRAUSE has obtained good results in asthmatics from  $\frac{1}{2}$  % ol. menth. pip.

### FOURTH MEETING.

President, Stoerk.

HERING (Warsaw), "*On the Curability of Tuberculous Laryngeal Ulcers.*"

He has seen eleven cases which prove the curability of tuberculous ulcers. He has also seen cures of such ulcers without medication. We cannot say that the disease is cured because the ulcers are cicatrized, since there are often recurrences both in the lungs and larynx. Of eleven cases described, three, because questionable, can be excluded. In the others, syphilis could be excluded with certainty. The ulcers were on the true and false ligaments, pars arytenoidei, and epiglottis. Their tubercular nature was certain from the contemporaneous affection of the lung and the presence of bacilli. In three cases, the cure lasted respectively nine, two, and one years; and in five cases half to three years. The larynx cured, the lung is ameliorated, the voice becomes better, and general improvement results.

A paper was read by MORITZ SCHMIDT (Frankfurt), "*On Tracheotomy in Laryngeal Phthisis.*"

The advantage of this method is not only to better respiration, but to deviate from the larynx the passage of irritating air. Eight cases were operated on, with good results. The following are the indications for operating:—

1. If there is stenosis the operation should not be delayed.
2. The laryngeal disease being marked, and the lungs comparatively healthy.
3. In rapidly-advancing laryngeal disease, before dyspnoea supervenes.
4. If dysphagia is present.

A paper was read by KRAUSE (Berlin), "*On the Therapy of Laryngeal Phthisis.*"

The author is sure that ulcers of the posterior laryngeal wall are curable by lactic acid. If there is not too much marasmus, no tuberculous ulcer can resist cicatrization by lactic acid. The pain of the treatment is no contra-indication.

SCHROTTER affirms the success of this treatment.

SCHNITZLER, while admitting that laryngeal phthisis is curable, remarks that every new medicament has had its temporary successes, and he believes iodoform to be better than lactic acid.

ROSENBERG makes applications of 20 % solution of menthol every day. He has had very encouraging results, and thinks the menthol efficacious by its anemia-producing, analgesic, and anti-parasitic qualities.

BETZ refers to two cases of tracheotomy in phthisis laryngis, both being women in the last month of pregnancy. The first, with large ulcers, was cured; the second died some weeks after the operation.

B. FRÄNKEL remarked that we can endeavour to destroy the bacillus, or to change its disposition. Lactic acid and menthol are both good. After this we can begin to individualize and adopt special treatment for every case.

(*To be continued.*)

### American Rhinological Association.

THE meetings were held at St. Louis, October 5, 6, 7, 1886.

A paper was read by Dr. H. JERRARD, of East Lynne (Mo.), "*On Necrosis of the Nasal Bones.*"

This condition is too often attributed to syphilis. Necrosis is sometimes *not* the result of a diathesis, but the *cause* of systemic conditions. These conditions are produced in non-specific cases by too irritant treatment. This must be pre-eminently soothing.

Dr. C. H. VON KLEIN did not believe a specific origin to be necessary for production of diseased bone. He recommended iodide of potash, and operative treatment locally.

Dr. RUMBOLD had seen a case produced by carbolic acid.

Dr. R. S. KNODE had never seen a case recover.

A paper was read by Dr. D. W. LOGAN, of Knoxville (Tenn.), "*On a Mixed Form of Atrophic and Hypertrophic Catarrhal Inflammation (heretofore undescribed), and its Treatment.*"

He had observed several cases of this condition, which would mislead some observers into saying that there was nothing abnormal. In the mixed form he found the atrophic element predominating in adults and children, generally the hypertrophic element greatest. The correct treatment is that adapted to atrophic inflammation. Treatment should always be directed to the atrophic condition when this existed, irrespective of hypertrophy.

A paper was read by Dr. O. F. BROWN, Lexington (Ky.), "*On Chromic Acid and Trichloroacetic Acid in the Treatment of Hypertrophies of Pharyngo-nasal Cavities.*"

Dr. KLEIN had used this treatment with success. Chromic acid acts satisfactorily if diluted and mixed with iodoform, one-quarter glycerine, and three-quarters acid, with 3 to 4 per cent. iodoform.

Dr. C. H. VON KLEIN read a paper, "*On Rhinology in the Past and of the Future*"; and Dr. I. W. FIRTH read a paper entitled, "*Thoughts relating to the Naso-pharyngeal Tracts.*"

A paper was read by Dr. J. R. VAN ALLEN, "*On Asthma, its Cause and Treatment.*"

He believed colds the most frequent cause, and the nasal and pharyngeal cavities the most common starting-point. In every case he had found a very severe chronic inflammation of the nasal and pharyngeal cavities. He had had marked benefit from treating the chronic nasal catarrh.

In the discussion following, there was a consensus of opinion that asthma could not exist without some nasal condition being present.

Dr. HOBBS read a paper, "*On Scarifications in Nasal Hypertrophies.*"

Dr. J. P. MATTHEWS read a paper entitled, "*Is Hay Fever (so-called) a Disease per se?*"

He believed pollen to be the sole cause; the dermatitis produced by poison-oak, poison-sumach, and the irritation of mucous membranes produced by pollen, to be analogous. It requires no dyscrasia, only a susceptibility to the plant, as predisposing cause. Heredity has nothing to do with it. It cannot be a disease *per se*, and it is not a neurosis. The treatment is preventive; the first indication

being to keep out the pollen; then to soothe the parts with sprays of vaseline, cocaine, and opium; finally, to change the residence. He had seen cases in which he could detect no nasal disease.

Dr. N. R. GORDON, of Springfield (Ill.), read a paper, "*On the Importance of Early Recognition and Treatment of Naso-aural Catarrh*," calling attention to the fact that many cases of impaired hearing in children were due to the neglect of nasal catarrhs.

Dr. RUMBOLD read a paper, "*On the Treatment of Pruritic Rhinitis (Hay Fever, Summer Catarrh, &c.)*."

He uses a spray of ℥ss. vaseline with guttæ ij.—v. of the following:—*Pinus Canadensis* gr. iij., glycerine ℥ij., *acidi carbolici* gr. ss., *ol. gaultheriæ* gutt. v., *aquæ ferri* ℥vj.—M.; warm before using, then spray with ℥ss. vaseline containing about five grains of the following (vaseline ℥j., *eucalyptol* gutt. v.—M.), cold. The eyes, if red and painful, may be anointed with vaseline. Prescribe a laxative, tonic, diuretic, and ten grains of quinine.

For thin patients he uses the galvanic current, the negative pole being placed over the solar plexus, the positive pole applied to the spine from the seventh cervical vertebra up to the hair, then to the bridge of the nose, eyebrows, and cheeks. The whole application lasts three minutes. It is frequently of greatest benefit during the acute attacks.

Cocaine always causes persistent congestion. Atropine in 5 per cent. solution applied on a small piece of cotton is better. Dr. Rumbold believes hay fever to be a neurosis from an inflammation.

Dr. O. F. BROWN stated that chromic acid always stopped the sneezing, asthma, and coughing.

### French Society of Laryngology.

OCTOBER MEETING, 1886. President, M. le Dr. MENIÈRE.

MOURA (Bourouilhon).—"On the Physiology of the Arytenoid Muscle."

Physiologists regard the arytenoid muscle as a constrictor of the cartilaginous glottis. Longuet has for the most part contributed to the acceptance of this view. Moura, from anatomico-physiological considerations, and from laryngoscopic observations on the movements of the two arytenoids, has come to the conclusion that these two cartilages approach one another posteriorly by their summits, but that they separate anteriorly.

This contradictory phenomenon in the movements of the base and those of the summit of the two pyramids is readily seen with the laryngoscope. Moura explains the mechanism of this. The dilatation of the cartilaginous glottis is produced altogether independently of that of the ligamentous glottis. Moreover it is accompanied by a very curious dry clapping noise at the moment when the *processus vocales* are detached from the posterior surface of the cricoid without being separated.

Moura had already recorded his discovery in his *Cours de Laryngologie*. He distributes the muscles of the larynx in the following manner: the most anterior effect the elongation of the cords; the median, their widening and approximation; the most posterior, their closure.

GOUGHENHEIM did not think that the arytenoids were separated in front by this muscle. Clinical observation and physiological experiments show, on the contrary, the adductor action of the arytenoid muscle on the vocal cords, especially at the posterior parts.

GELLÉ.—“*Grave Epistaxis—Posterior Tampon—Bilateral Purulent Otitis.*”

Many authors are opposed to the tampon, seeing that certain epistaxes are salutary, while fatal results have been observed after therapeutic intervention. Gellé, for his part, has seen in a patient, a double suppurative otitis supervening upon a serious attack of epistaxis. The subject was tamponned, and the posterior tampon was retained for forty-eight hours. Gellé believed that the blood retained in the nasal fossæ decomposed and was driven by deglutition into the tympanic cavities, where it excited inflammation, rapidly advancing to suppuration. Gellé then related three cases of epistaxis accompanied with hæmorrhagic otitis, where the application of the tampon had not been practised, which seemed to discredit the value of the preceding conclusions.

MIOT, BOUCHERON, did not see in the relation of the first case with *tamponnement* any evidence that the blood penetrated into the skull.

BARATOUX had observed two analogous cases. Two days after the application of the tampon, he observed the presence of blood in the ear, and a double purulent otitis was the consequence.

MOURA.—“*Anomaly in the Thyroid Insertion of the Right Vocal Cord of a Child of One Year.*”

The child died from a cerebral affection. The right vocal cord was formed of two parts, separated by a cartilaginous nodule, giving rise to a little transverse mucous fold, which lost itself in the ventricle. The anterior part had the appearance of mucous membrane, the posterior that of white pearl, that is, of the vocal ligament. The cartilaginous point was no other than the tubercle of insertion of the cord detached from the thyroid. At what period of intra-uterine life was this anomaly produced? Is it the result of an arrest of development? Moura put these questions without solving them.

CHATELLIER.—“*Post-nasal Fibro-mucous Polypus—Division of the Tumour—Extirpation—Histological Examination.*”

The polypus was so large that the snare could not pass between it and the septum of the nasal fossæ; the instrument was introduced by the opposite nostril, and with two attempts the part that overreached the middle line was divided. With the wire snare the polypus could then be extracted. There was no hæmorrhage. The point of origin of the tumour was the summit of the nasal fossa between the superior turbinated bone and the septum, about a centimetre from the choanæ. The histological examination showed at the centre of the tumour simple mucous tissue, at the periphery old fibrous tissue, and in the intermediate zones the two tissues mixed. The tumour was but slightly vascular. JOAL.

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## REVIEWS.

### On the Function of the Nose in Respiration.\*

DR. THEODOR ASCHENBRANDT has published, under this title, a series of experiments made by him in the Physiological Institute of Professor FICK, in Würzburg, in order to find the nearest possible answer to some questions, the importance of which has long been felt. These questions, as he puts them, are: I. To what degree of

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\* “Ueber die Bedeutung der Nase im Respiration;” Th. Aschenbrandt.



temperature is the air raised in the nose when respired under ordinary circumstances? II. In what measure does it get saturated with water in the nose? And III. In what measure does the nose protect the lungs against the introduction of solid suspended matter?

The method followed by the author is shortly as follows:—By means of an aspirator of a capacity of 5 litres, which is connected with one of the nostrils by a glass tube, he makes a certain quantity of air pass through the nose in such a way that it exits at the other nostril. Every six seconds one litre of air is respired, and in thirty seconds the experiment is finished. A thermometer in the glass tube gives exactly the temperature of the air as it leaves the nose. Aschenbrandt found this temperature to be  $30^{\circ}$  C. when the temperature of the air in the room was  $12^{\circ}$ , and he found it to be the same when this was  $8^{\circ}$ . Now, the air when it leaves the nose in ordinary respiration has, as a rule, a temperature of  $50^{\circ}$  C., which leads to the conclusion that the warming of the air in respiration is done almost exclusively by the nose.

The experiments regarding the degree of saturation of the air with water, were made with the same aspirator; but in the air expired from the nose the water was determined very carefully. It was found to contain 0.18 grams in 5 litres, which corresponds to a complete saturation; accordingly, the whole quantity of water which the air in respiration withdraws from the human body, and which amounts to about 500 grams, is taken from the mucous membrane of the nose, and the whole loss of heat brought about by the evaporation of that water has to be sustained by the nose, and does not lower the temperature of the lungs, as has generally been admitted by physiologists.

As to the retention in the nose of solid suspended matter, Aschenbrandt found, what is well known to everybody, that what he calls chemical dust—*e.g.*, chloride of ammonia, freshly formed by bringing ammonia and hydrochloric acid together in gaseous form—is not retained in the nose. But when he made experiments with fine starch-powder, not a particle was found to pass through the nose; it was kept back, partly in the one nostril through which the air entered into the nose, and partly in the naso-pharyngeal cavity.

To meet the objection that in his experiments the air passes consecutively through both nostrils, Aschenbrandt modified them in such a manner that the air was introduced through the mouth behind the soft palate by means of a large glass tube: he found the results very nearly the same.

These experiments seem to have given a more definite proof than we had of the threefold function of the nose in respiration. They are a very welcome confirmation of the theory which regards respiration through the mouth as a source of danger to the whole respiratory system, an opinion which prevails more and more among those who have given their attention to the subject. (See MORELL MACKENZIE [German translation by FELIX SEMON], ii., p. 517.) GUYE.

*Amsterdam, November, 1886.*

**Manuel Pratique des Maladies des Fosses Nasales et de la Cavité Naso-pharyngienne, par J. MOURE.** *Paris: Octave Doin, 1886.*

IF a compilation is ever a desirable production—and for the sake of students we must allow it—the handbook before us can merit little but praise. Written with a terse, concise diction, such as is hardly possible in any but the French language, M. Moure obviously aims at placing before his reader the existing position of his subjects. While referring constantly to Continental authors (whose books and their dates, however, he seldom cites), he hardly does justice to himself in this his special branch of work. Occasionally, however, we have a refreshing assertion as to personal experience, which, perhaps, gains weight from its infrequency. Especially will be valued the author's remarks on atrophic rhinitis, and we grow hopeful from his emphatic assurance of the curability of ozæna (p. 104); while two pages further on he promises us, at a future date, the results of his observations concerning the regeneration of the atrophied structures. Are we to infer that the turbinated bones are ever reproduced?

The section styled *Neuroses reflexes d'origine nasale* is interesting as an admirable *resumé* of current experiences and opinions. But we are somewhat surprised that while M. Moure shows considerable familiarity with American work, he seldom quotes an English author. In this very matter of nasal neuroses, one at least of our specialists might consider himself entitled to a passing notice, although on the Continent, as in America, his theories are apparently ignored.

The type is clear, and the illustrations are, for the most part, correct, but the index is quite insufficient, and the list of works referred to in the text is sadly incomplete. We can, however, cordially recommend the book to students and practitioners.

GREVILLE MACDONALD.

**Lectures on Lepra**, by **T. L. BIDENKAP**. *Christiania: Huseley & Co.; London: Williams and Norgate.* 1886.

ACCORDING to Bidenkap the manifestation of leprosy in the nose, the pharynx, the mouth, the larynx is a frequent but late symptom in that form of leprosy which the author calls *lepra tuberosa* (this form, however, being rarely pure but mixed with the other—*lepra nervorum*). The eruptions in the mucous membranes of the organs just mentioned are the same as in the skin, viz., granulations, in which the characteristic bacillus *lepræ*, discovered by Armauer Hausea, is always to be found on microscopical examination, and which is by most authors thought to be the cause of the disease. The leprous deposits in the organs here concerned are generally observed first on the soft palate and uvula, from whence they proceed forward in the form of infiltrations and tubers, reaching the back part of the hard palate and the alveolar process, forming often a wedge-shaped figure. They often also extend over the pillars of the fauces, the tonsils, which, however, never swell much towards the tongue, and the mucous membrane of the cheeks. The tubers formed in these parts, varying in size to that of a pea or more, have a much greater tendency to ulcerate than those of the skin, especially when the patient is cachectic.

Increased secretion and impaired breathing through the nose often indicate that the pituitary membrane is likewise affected. Here the destructive process develops much quicker, causing fetid discharge and large deficiencies of the septum, with consequent disfigurement of the nose, which forms a characteristic feature of the typical aspect of lepers.

The leprous symptoms of the larynx are generally later than the ones just mentioned, and the leprous products here are less destructive. The first symptom is hoarseness, but not unfrequently breathing becomes difficult. Tracheotomy has to be performed, which generally arrests asphyxia for a time. The epiglottis is much swollen, as are also the vocal cords, which the author describes as having generally a tubercular, uneven, and reddish appearance.

Although the author's description of the leprous symptoms in the organs in which the readers of this journal are particularly interested is neither exhaustive, nor adds much to characterize the leprous deposits in these organs, the book, which is written in English and furnished with good coloured plates, is very interesting and worthy of attention.

HOLGER MYGIND.

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THE PHARYNGEAL BURSA IN POST-  
NASAL CATARRH.

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ATTENTION has recently been called to this condition by Tornwaldt, of Dantzig (*Ueber die Bedeutung der bursa pharyngea für die Erkennung und Behandlung gewisser Nasenrachenraum-krankheiten: Wiesbaden, 1885*), who attributes to the bursa an important rôle in the production of certain forms of naso-pharyngeal affections.

Luschka (*Der Schlundkopf der Menschen: Tübingen, 1868*) first described the "pharyngeal bursa." According to him there is found often, if not always, at the lower border of the adenoid tissue of the pharynx, an orifice of larger size and of a different significance from those of the other glands there; rounded, of the size of a pin's head, sometimes larger, bounded above by a projecting cushion, and presenting a cul-de-sac of oblong shape,  $\frac{1}{4}$  inch in width and  $\frac{3}{8}$  inch in length. The bursa extends in the direction of the basilar process, and is surrounded by fibrous tissue. At its posterior part occur glandular acini, or muscular fibres. It is in relation posteriorly with the pharyngeal ligament, which is attached to the pharyngeal spine. Luschka thought this organ was of importance, and assigned to it the two cysts of this region described by Troltsch and Czermak. Fraenkel (in *Ziemssen's Encyclopædia*) mentions an opening of the size of a poppy seed leading into a sac situated behind the mucosa, probably connected in the embryo with the hypophysis cerebri. F. Ganghofner (*Ueber die Tonsilla und Bursa Pharyngea: Sitzungsberichte der k. Akademie der Wissenschaften, October, 1880*) regards it as the remains of the foetal canal, which unites the hypophysis to the anterior aditus. Schwabach (*Laryng. Sect. der 59 Versammlung deutscher Naturforscher und Aerzte in Berlin, 1886*) denies the existence of a flask-shaped appendage to the pharyngeal vault, and declares this so-called bursa to be a simple depression of the mucosa, which is not invariably found; and that, exceptionally, there exists in the site of the depression, a single hole, which is the superior termination of the centra

median channel at the back of the pharynx. In a large number of cases Schwabach holds that what has been described as the pharyngeal bursa is nothing more than the space formed by the superficial coalescence of the two inner lips of the lateral ridges seen at the back of the pharynx, anterior to, and enclosing the upper extremity of the central median furrow. Tissier (*Etude de la bourse pharyngée, Annales des Maladies de l'oreille, &c.*, October and November, 1886), in a very complete summary of this subject, maintains that it is not an abnormally developed gland of the mucosa, nor an analogue of the tonsillar crypts; also that the orifice is on the posterior, not the superior wall. Luc (*France Médicale, October, 1886*) states that the orifice is found in the middle of the adenoid tissue of the superior wall of the pharynx, that is, in the middle of the pharyngeal tonsil. This is in opposition to the statement of Luschka, and is stoutly denied by Tissier, who has made careful observations in a child with complete cleft palate. Tornwaldt does not attribute any particular importance to the name "bursa" (which it obviously is not, in the anatomical sense of the word).

A large number of observations prove that the appearances of this bursa vary. Sometimes it is a shallow funnel-shaped depression, without apparent orifice; or there is an elongated slit,  $\frac{1}{8}$ -in. long, with sharply-defined lips on a level mucosa; and from the slit an opalescent mucus exudes. At others, a firm plug of muco-pus lies over the site, somewhat like the core of a boil, which on firm pressure is extruded from an evident cavity.

The bursa is to be sought for in the following manner:—

1. A Voltolini's palate hook should be used (the smallest size laryngeal mirror, bent to an angle of  $45^\circ$  with the shank, answers perfectly for pulling forward the soft palate).
2. The subject must be rendered tolerant by cocaine or by practice (20 per cent. cocaine spray answers in nearly every case).
3. The tongue must be well depressed by the patient holding the spatula.
4. The reflecting mirror should be kept almost horizontal.
5. The septum narium should be got first into view, and then the superior surface scanned from before backwards.

Tornwaldt states (*loc. cit.*) that whatever may be the nature of the "pharyngeal bursa," it is covered with a mucosa, on the surface of which secretions are produced, scanty in the normal state, and constantly renewed, but increased in morbid conditions, resulting either in chronic catarrh of the bursa, or retention-cyst if the orifice be obliterated.



The symptoms are, dryness of throat, continuous slight pain, frequent desire to cough or hawk, especially in the morning on waking, the dislodgment of a more or less greyish-yellowish firm and sticky mass being followed by a sense of comfort. Such patients have undergone treatment without avail, but are better when they abstain from smoking.

The pharyngeal mucosa is smooth, level, shining, pale, varicose at points, sometimes reddish blue and dotted with minute elevations. Below the velum palati, which obstructs the view of the upper posterior pharyngeal wall, there is a typical little crescent of thick, firm, dirty yellow mucus, convex at the lower border, or festooned, presenting stalactites of mucus. Mucus extends upwards to a point midway between the septum narium and the prominence of the atlas, where it stops, thus leaving a triangular bed of mucus about the size of a franc piece, or muco-pus, more or less piled up and dried. Tornwaldt argues that this does not come from the nose, because of the absence of mucus between the septum and the apex of the pharyngeal triangle of muco-pus; nor can it be deposited by the soft palate there, from considerations of gravitation; nor can it come from the *general* surface of the pharyngeal mucous membrane, or why the localization of deposited secretion? *A priori*, one would expect it to come from the adjacent *cul-de-sac*, *i.e.*, the bursa pharyngea, because of—(1) The arrangement of the muco-pus; and because (2) Plugs of muco-pus extending from the pharynx may be sometimes seen to be fixed in the cavity, and may be expressed with a probe, together with more or less generally odourless secretion of a white, blackish, or sanguineous colour.

Several illustrative cases have been quoted by Tornwaldt (*loc. cit.*), Keimer (*Monatschrift für Ohrenheilkunde*, May, June, and July, 1886), Broich (*Monatschrift für Ohren., &c.*, p. 153, May, 1886), Tissier (*loc. cit.*), Luc (*loc. cit.*). Hypersecretion from this bursa, when the orifice is closed, leads to a retention cyst, as first surmised by Luschka. The symptoms of such a cyst are, according to Tornwaldt, pains in the throat, chronic pharyngitis, auditory troubles, difficulty in nasal respiration, and a peculiar timbre of voice. This condition is often a sequel of chronic saccular catarrh, which has led to contraction, and finally closure of orifice. The pharynx presents the ordinary signs of chronic pharyngitis, and posterior rhinoscopy shows the naso-pharynx more or less contracted in the antero-posterior direction, and a swelling varying in size from a hemp-seed to a walnut, sometimes white, but more often red and shining with the point of termination on the site of the pharyngeal bursa.

The contents of these cysts have been several times examined, and an albuminous, colourless, yellowish, or reddish viscous fluid is found, sometimes thick and creamy and like a gritty soup. Tornwaldt asserts that while the treatment of chronic pharyngitis alone is quite inefficacious, the cure of the malady affecting the bursa is promptly followed by cure of all the accidental symptoms, which he describes as follows :—Chronic laryngitis, with hoarseness, dysphonia, or even aphonia, which may be accounted for as resulting from mechanical irritation either (1) from impeded nasal respiration, allowing draughts of cold air and dust to impinge on the larynx, or (2) from the constant fall of mucus from the pharyngeal mucous membrane on the larynx, or (3) the laryngeal inflammation may be a reflex inflammation. Tornwaldt has seen in one case a paralysis of the arytenoideus cured as a result of operation on the pharyngeal bursa (*loc. cit.*, p. 96). Various troubles of the nose, such as hyperæmia, hypertrophy, and atrophy of mucous membrane, epistaxis, and swelling of the turbinated bones, occur in association with bursal affections, and Tornwaldt has known a nasal polypus disappear after cure of saccular disease. Eustachian catarrh, purulent middle ear catarrh, humming noises in the head, hardness of hearing, and even deafness are attributed in some cases to bursal affections.

Tornwaldt has also noticed pains in parts more or less remote—sternal, frontal, occipital, and neck pains. These morbid sensations were rare in saccular pharyngitis, accompanied with ordinary mucous secretion, more frequent with muco-purulent secretion, and almost constant when the mucus was abundant, thick, and adherent to the mucosa. Bursal affections also produce mechanical pharyngeal cough, the object of which is to dislodge morbid secretion from the pharynx: laryngeal cough to expel the mucus from the larynx; guttural cough, excited by reflex stimulation of adherent fibres of vagus in the pharynx; cough from secondary lesions in the larynx; sneezing; and even attacks of true asthma and bronchial catarrh; vomiting and nausea are also referred by Tornwaldt to gastric catarrh brought on by continued flow of mucus into the stomach. It is quite certain that all the above symptoms are not unfrequently met with in association in a great number of patients, even if not causally connected, as is maintained by Tornwaldt and others.

It is well to bear in mind that all the affections which attack the naso-pharynx, such as common catarrh, scarlatina, variola, diphtheria, &c. &c., can leave traces of their presence in the pharyngeal bursa; and when we meet with pharyngeal bursitis, or bursal cyst, it should be recognized as itself a sequel of an anterior morbid state. Con-

sidering the universal liability to some of the above affections, the question arises: Is the bursa ever found healthy? Considerations of depth, shape, and exposure to irritation, and perhaps even constitutional peculiarities, will suggest the answer.

Tornwaldt (*loc. cit.*) states that of 1,603 cases, in two years, of nose, throat, ear, and lung disease, 892 had affections of naso-pharynx. Of these, 202 had bursal affections, viz., 157 hypersecretion, and 45 cystic tumours. The treatment recommended by Tornwaldt is, in the first place, simply palliative (until perfect tolerance is obtained) by cleansing solutions, insufflations of astringent powders, and painting the site of the bursa with a 10 per cent. solution of nitrate of silver. Later, he recommends the passage of a stylet covered with fused argentic nitrate through the orifice into the cavity of the bursa, and thorough cauterization of its walls, but more especially the introduction of a specially curved *galvano-cautery* into the bursa, as being radical, active, and certain. It is possible that in some cases this bursa may become the seat of acute suppuration and the origin of retro-pharyngeal abscess.

R. H. S.

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## THERAPEUTICS AND INSTRUMENTS.

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**HOWARD SMITH.**—A Device Intended to Facilitate Application to the Posterior Nares or Larynx. *New York Medical Record*, August 7, 1886.

THE india-rubber tubing of the atomiser is to be lengthened to about five feet, so that the bulk of it lies on the floor, and the bulb can be worked with the operator's foot, while the mirror can be held in the one hand, and the bottle and spray tube with the other.

**EATON, F. B.**—Some Improved Forms of Burners for the Galvano-Caustic Treatment of Nasal and Post-Nasal Hypertrophies. *New York Medical Record*, August 28, 1886.

A DESCRIPTION of several new forms of burners, which to be understood must be read alongside the illustrations which accompany the paper.

**PHILLIPS, W. C.**—A New Throat Applicator. *New York Medical Record*, October 30, 1886.

THIS is the uterine applicator modified in length, size of handle, and stem, and in the material used, being made of sterling silver, filed down at the distal end, so as to be sufficiently flexible to be bent into

any desired curve for application to the nose, pharynx, or larynx. It can be used as a probe, cotton-holder, or applicator. The remainder of the stem or shank is inflexible. Absorbent cotton should be wound round the end of the instrument, loosely at the distal and tightly at the proximal end, to prevent it slipping off when withdrawn.

**THOMPSON, J. A.**—**A New Nasal Illuminator.** *New York Medical Record*, November 6, 1886.

A SMALL incandescent lamp is mounted on a metal tube, curved on a short radius to an arc of 90°. It is protected from injury by the throat muscles, by a metal shield, the inner side of which is polished, and serves as a reflector. It is movable, and can be turned so as to throw the light on either Eustachian orifice, through the nose or on to the posterior wall of the pharynx, and can also be removed for cleansing. The tube and lamp are provided with a hollow wooden handle. Three cells of an ordinary galvanic battery suffice to light the lamp.

The lamp can easily be guided into the naso-pharyngeal space, the distance from the bottom of the tube to the top of the lamp being less than three-fourths of an inch.

**BÜRKNER** (Göttingen).—**The Use of Auer's Light for Medical Purposes.** *Berlin Klin. Woch.*, No. 29, 1886.

THE writer strongly commends this light on account of its easy application to every gas, and its cheapness. The natural colours of the tissues are maintained.

MICHAEL.

**NYROP.**—**Electrical Light Apparatus.** (*Electrische Beleuchtungs-apparate für Aerztliche Zwecke.*) *Central. f. Ch. und Orthopaed. Mechanik*, 1886, No. 13.

DESCRIPTION of electric light, fixed on to frontal bandage, and produced from accumulators.

MICHAEL.

**VOLTOLINI** (Breslau).—**Ueber Electrolytische Operationen mit Demonstration von Instrumenten.** (*Electrolytic Operations with Demonstration of Instruments.*) *Monatschr. für Ohrenheilkunde*, October, 1886.

A PAPER of the greatest importance and interest. Neither knife, scissors, nor galvano-cautery are without accidents of suffocation or fatal bleeding, or the non-completion of the operation, in operations for the removal of fibrous and fibro-sarcomatous tumours of the naso-pharynx. The author, therefore, recommends electrolysis. This

method is not followed by bleeding. The old method of applying one of the electrodes to the head or neck is not to be employed. The author at first used two needles to destroy the tumour, but there is the possibility that, in destroying the tumour, the needles, going deeper and deeper, may reach the meninges, if the bone is already perforated by the tumour. The author lost one patient from meningitis in this manner. He has, in consequence, devised electrolytic scissors and pincettes, and also a battery for electrolytic purposes, which can be obtained at a moderate price; also an electrolytic cutting wire for the removal of polypus and other neoplasms, without hæmorrhage. The author finally asserts that naso-pharyngeal tumours show no recurrence if they are removed rhinoscopically. A patient with retropharyngeal fibroma was operated upon by Professor Langenbeck. In one year it recurred. Operated on by the author rhinoscopically, the patient has been for ten years without recurrence.

MICHAEL (Hamburg.)

**BRADÉ.**—*Kleine Tauchbatterie nebst Nadeln zur Electrolyse von Prof. Voltolini in Breslau.* (Prof. Voltolini's small Battery, with Needles for Electrolysis.)

A DESCRIPTION of the battery, &c. (See report of the German Naturalists and Physicians' Congress.)

MICHAEL.

**LUBLINSKI.**—*Ueber die Iodol-Behandlung der Larynx-Tuberculose.* (The Iodol-Treatment of Laryngeal Tuberculosis.)  
*Sonderabdruck aus der Deuts. Med. Woch., No. 51, 1886.*

IODOL is scarcely soluble in water, but is dissolved by alcohol and ether. Schmidt proposed a mixture of iodol, 1 part; alcohol, 16 parts; glycerine, 34 parts. This is, however, too weak. Lublinski has used the powder pure for laryngeal insufflation. It causes no pain or cough, and it remains a long time in contact with the surface. The author has used it in the treatment of fifteen cases of tuberculosis. He administered one insufflation daily, or, in some cases, two or three times a week. Under its influence ulceration quickly heals, the base becoming clean and granulating, dysphagia disappears, and the patient's health improves. Tannin, boric acid, lactic acid, and other applications will produce this effect, but not so rapidly as iodol, the action of which is striking. The author gives details of two cases of tuberculosis in particular, in which iodol produced rapid curative effects. In both there was extensive ulceration. The author also regards iodol as serviceable in ozæna and scrofulous rhinitis, with ulcers on the septum.



**BERGEON ET MOREL.**—Results of the Method of Gaseous Rectal Injections in Simple Inflammatory and Tubercular Laryngitis, Ulcerations of the Respiratory Passages, Pharyngitis, &c. (*Resultats de la Methode des Injections Rectales Gazeuses dans la Laryngite, Simple Inflammatoire, et Tuberculeuse, les Ulcerations des Voies Respiratoires, la Pharyngite*: G. Masson, Boulevard St. Germain, &c.)

DR. BERGEON has abandoned local treatment in laryngeal phthisis, and has employed the method of rectal clysters. He has always obtained by this means rapid amelioration of the throat pains, disappearance of spasm, and complete cicatrization of the ulcers. A patient with such pain on swallowing that he had not eaten for three days, was relieved quickly by the treatment with gaseous enemata. The throat pains diminished, and in three weeks the ulcers began to cicatrize, which process has continued since. Bergeon employs by preference carbonic acid, and he injects four to five litres a day, in two injections. M. Cornil and M. Chantermesse, experimenting with this method of treatment, have obtained excellent results in the treatment of respiratory affections. JOAL.

## DIPHTHERIA.

**CLIBBORN, J. B.**—A Case of Diphtheria of the Vagina without the Throat being affected. *Lancet*, No. XIX. Vol. II. November 6, 1886.

A WOMAN, attending her child suffering from diphtheria, was scratched by him on the wrist. Isolated painful vesicles appeared without pyrexia; healed, and were succeeded by similar vesicles round the nipples; still no pyrexia. These disappeared. The patient all the time felt weak, which increased. Anorexia and insomnia, along with fœtid vaginal discharge, came on. The mucous membrane of vagina was inflamed, and covered in parts with false membrane; constitutional symptoms followed, asthenia, delirium, delusions, and albuminuria. Highest temperature 99° 4. The woman, who was pregnant, developed labour pains. Miscarriage was averted by large doses of opium. Ten days after appearance, the false membrane disappeared and convalescence was rapid. The throat was never affected. The treatment was carbolic acid ℥j, glycerine ℥x, tinct. quiniæ ʒj, water to ʒj, every three hours, and local treatment with iodoform and vaseline, and syringing with potass permanganate.

The author speaks highly of this plan of treatment in other cases.

**CLEMENS, J. M.** (Louisville).—Diphtheria and Croup. *Progress, July, 1886. Extracted from the New York Medical Record, August 7, 1886.*

DR. CLEMENS thinks that the "unity theorists" ignore the fact that there exists a non-specific, non-contagious, idiopathic, membranous croup, which is perfectly distinct and distinguishable from diphtheritic laryngitis, and he enumerates the points of difference.

In diphtheritic croup there is a prodromal stage of two or more days, without hoarseness or cough, with constitutional disturbance, elevated temperature, subsiding after the onset, even to subnormal point, and rising again with the invasion of the larynx and trachea. In true croup the onset is sudden, or following exposure to wet or cold, within a few hours, little or no constitutional disturbance, elevated temperature, continuing till amendment is established. In diphtheritic croup, there is mottling or irregular reddening of the fauces, often more conspicuous on one side than the other. In true croup, the fauces are never mottled, but uniformly pale red or bright red, and free from loose secretion. Enlarged and painful lymphatic glands, particularly the submaxillary, occur in diphtheritic croup, but there is never any submaxillary enlargement in true croup. Exudation on the tonsils, fauces, nares, lips, &c., occurs in diphtheritic, but never in true croup. Early albuminuria is the rule in diphtheritic, but never in true croup. A peculiar foetid breath occurs in diphtheritic, but never in true croup. Diphtheritic croup is a general asthenic disease, while true, or pseudo-membranous croup is a local sthenic affection.

**TRIFILETTI, A.**—On a Case of Primary Diphtheria of the Nasopharynx, and Remarks on the supposed Analogy between Diphtheria and Scarlatina. *Archiv. Ital. di Laring., An. VI., Fasc. 1 and 2.*

THE author brings forward a case of primary diphtheria of the nasopharynx, occurring in an individual who had been in such intimate relations with patients suffering from measles and scarlatina, that one might reasonably suppose not only an identity between diphtheria and one of these diseases, but even the existence of a secondary diphtheria.

It is a well-devised article, and eminently clinical in scope.

MASSEI.

**WOLFENDEN, NORRIS.**—Athetosis occurring after Diphtheria. *Practitioner, 1886.*

THE author describes the case of a young girl of nineteen con-

valescent from a severe diphtheria, in whom there was paresis of the right side, arm, and leg; feelings of pins and needles in the fingers and toes, and occasional pains in the right shoulder. Athetosis in the fingers and toes of the right side was marked, accompanied by intermittent spasm of the arm. There was no history of nervous complaints in the girl herself, but the mother and father gave a very nervous history (migrains, sunstroke, and violent temper). Recovery was rapid under perchloride of iron. This is the first time, the author believes, that athetosis has been recorded as a sequence to diphtheria. Whether athetosis is a lesion of the internal capsule, or the symptoms recorded had anything to do with a peripheral neuritis, the author does not venture to say, but thinks the case important as bearing on the pathology of this obscure condition.

**LATOUR, TOLOSA.**—Popular Instructions for the Prevention of the Propagation and Ravages of Diphtheria (Garrotillo, Gangrenous Quinsy, Croup). (Instrucciones Populares para evitar la Propagación y Extragos de la Diftéria, Garrotillo, Angina Gangrenosa, Crup.) Prize Essay. *Spanish Hygienical Association. Madrid*, 1886.

IN the space of only sixteen pages the author defines with exactness and precision the symptoms of diphtheria, the differences between its forms as occurring in the child and the adult; discusses the care of the patient, the measures to be adopted to restrain the propagation of the disease, and the rules necessary to prevent its ravages. He gives a few medical formulæ, discusses the practice of disinfection, the mortality of diphtheria, and ends with a few statistics as to the mortality from diphtheria and croup in Madrid, which has been in 1880, 242; in 1881, 199; in 1882, 187; in 1883, 1027; in 1884, 1102, or for the year 1884, 7 per cent.

RAMON DE LA SOTA Y LASTRA.

**MARTINEZ, ARAMBURO.**—Prognosis in Diphtheria. (El Pronóstico en el Diftéria). *Anales de Obstet., Gynec. y Ped. Madrid*, November, 1886.

MARTINEZ, basing his conclusions on the study of 114 cases of this complaint (published in *El Siglo Médico*), says that diphtheria can be divided into five forms or varieties: 1st, The slight or diphtheroid; 2nd, The grave form, with infection, false membranes on the pharynx and soft palate being the anatomico-pathological feature of this form; 3rd, The grave and infecting form, false membrane being slight, but tissue destruction in the pharynx prevailing; 4th, Laryngeal

diphtheria, or "garrotillo;" 5th, Hyper-toxic, or malignant diphtheria. The prognosis is very good in the first variety, must be very grave and guarded in the second form, grave but hopeful in the third, gravest in the fourth, and absolutely hopeless in the fifth variety.

RAMON DE LA SOTA Y LASTRA.

**GONZALEZ, DOMINGO.**—Salicylic Acid in the Treatment of Diphtheritic Coryza. (*El Ácido Salicílico en el Coriza Diftérico.*) *Gaceta Médica Catalana. Barcelona, September, 1886.*

GONZALEZ concludes: 1st, Diphtheria is a local disease, always dangerous, but curable if from the first local treatment is energetic; 2nd, Cauterizations with nitrate of silver, or hydrochloric acid, constitute the best treatment; 3rd, When the disease attacks the nasal fossæ, cauterizations being impossible, insufflations, or irrigations, of antiseptics must be employed; 4th, Salicylic acid is the best of these agents, being acid, antiseptic, and non-toxic; 5th, Sprays of 4 per cent. solutions of chlorate of potash and borate of soda aid the cure.

RAMON DE LA SOTA Y LASTRA.

**BROUARDEL.**—The Treatment of Diphtheria by Benzoate of Soda and Calcium Sulphide. (*Traitement de la Diphtherie par le Benzoate de Soude Associé au Sulfure de Calcium.*) *Gazette des Hôpitaux, December 11, 1886.*

A MIXTURE is made of 150 gr., containing 4 to 5 gr. benzoate of soda, according to the age of the child. Sulphide of calcium is given at the same time in granules or syrup. Besides this, in grave cases, pulverizations must be made with a 10 per cent. solution of benzoate of soda, night and day. In less severe cases, sleep need not be disturbed. Under this treatment, says Brouardel, one sees the false membrane pale, lose its consistency, become more and more gelatinous, and disappear, dissolved by the benzoate of soda, leaving the skin beneath cicatrized. The treatment is followed by continuous vaporizations of phenic acid, eucalyptus, and turpentine. Dr. Brouardel maintains that he has obtained constant success by this plan of treatment, and affirms that practising in Algeria, where diphtheria makes great ravages, he has not lost one patient out of more than 200 cases treated by him.

JOAL.

**BRASCH.**—Diphtheritic Paralysis cured by Injections of Strychnine. (*Zur Therapie schwerer diphtheritische Lähmungen mit Strychnininjectionen.*) *Med. Wochens, 1886, No. 48.*

A CHILD of four had, after diphtheria, paralysis of the palate, neck, and muscles of the upper and lower extremities. The condition was completely cured by eighteen injections of strychnine. MICHAEL.



## N O S E.

**LUBLINSKI, W.**—Asthma and Nasal Disease. (*L'Asthme et les Affections Nasales.*) *Read before the Medical Society of Berlin, 1886.*

AFTER answering affirmatively the question as to whether there really exists any intimate relation between asthma and nose disease, the author proceeds to examine the various prevalent theories. He dismisses, without comment, such as attribute the asthma to occlusion of the nose or to extension downwards of the nasal affection, and devotes the bulk of his paper to discussing the theories of Hack. But although holding with this observer in the main, he objects to the narrow limits to which he has tied himself. For while Hack teaches that reflexes produced by irritation of portions of the nasal mucous membrane other than the erectile tissues, are consequent upon a secondary swelling of the latter, Dr. Lublinski points out that the *nervi erigentes* are purely hypothetical. Further, the author indicates that the impossibility of separating the mucous membrane from the erectile tissue with which, according to Zuckerkandl, it is in direct continuity, destroys his theory that hypertrophy of the mucous membrane prevents the development of reflexes due to turgescence of the erectile bodies, as well as his conclusion that the frequency of nasal asthma is in inverse proportion to inflammation of the mucous membrane. The paper ends with an account of the author's methods of treatment, which, however, do not differ from those usually adopted.

GREVILLE MACDONALD.

**MENOCAL.**—Naso-pharyngeal Fibroma. (*Fibroma naso-faringeo.*) *Revista de Medicina y Cirugia Prácticas. Madrid, December, 1886.*

THE fibroma was attached to the basilar process, and was of the size of a small orange. The soft palate was cut transversely, near its junction with the hard palate, by the thermo-cautery, and through this opening (of 4 centimètres) Menocal introduced a small sharp Volkmann's spoon, and vigorously separated the tumour from its basilar insertion, and drew it out through the mouth. There was much hæmorrhage, which, however, was controlled by cotton plugs, and strong solutions of chloride of zinc. The site of the tumour was scraped. A month after the patient was thoroughly cured.

RAMON DE LA SOTA Y LASTRA.

**HEYMANN** (Berlin).—On Nasal Polypi. *Berlin Klin. Woch.*, Nos. 32 and 33, 1886.

A GENERAL review of the methods of operating for nasal polypi.



The author recommends the cold wire, and, in case of need, the galvano-cautery.

MICHAEL.

**LOEWY** (Berlin).—On Curvatures of the Septum Narium. (Ueber Verkrümmungen der Nasenscheidewand.) *Berlin Klin. Woch.*, No. 47, 1886.

A LARGE number of examinations by the author prove that curvations of the septum are often co-existent with a very small and arched hard palate. There is also a prominence of the median part of the palate, and of the teeth. A similar state of the palate has already been described (first by David), as associated with adenoid vegetations. The author believes that rickets is the cause of both affections.

MICHAEL.

**HABERMANN** (Prag).—The Pathological Anatomy of Ozæna Simplex seu vera. (Zur pathologischen Anatomie der Ozæna seu vera.) *Zeits. für Heilk.*, Bd. VII.

FROM a very exact microscopical examination of two cases, the author concludes, that the nature of ozæna consists in a fatty degeneration of the acinous glands of the nasal mucous membrane, and of Bowman's glands, along with an inflamed and infiltrated mucous membrane. The fibrous degeneration of the neighbouring membrane, and the atrophy, are caused by this condition inducing reaction in neighbouring parts.

MICHAEL.

**FRAENKEL, B.** (Berlin).—Diseases of the Nose, Larynx, and Trachea. (Krankheiten der Nase, des Kehlkopfs, und der Luftröhre.) *Virchow-Hirsch Jahresbericht, ueber die Leistungen und fortschritte der ges. Med.* 1886.

AN annual review of all the papers published in 1885.

MICHAEL.

**GONGORA**.—Varicose Ulcer of the Posterior Inferior part of the Nasal Septum. (Ulcera Varicosa de la parte Posterior Inferior del Tabique Nasal.) *Revista de Laryngologia, Otol. y Rinologia.* Barcelona, November, 1886.

THE author read, at the Spanish Laryngological Association, the history of a patient, who for three years had hæmoptysis; there was no thoracic condition to account for it, but Gongora discovered a coagulum on the posterior part of the septum, under which was an ulcer of one centimètre in diameter. The galvano-cautery and the sulphuretto-iodated waters of La Puda cured the condition.

RAMON DE LA SOTA Y LASTRA.

**GONGORA.**—Contribution to the Study of the Affections caused by Hyperæmic States of the Cavernous Tissue of the Inferior Turbinated Bones. (Contribucion al Estudio de las Afecciones Sostenidas por Estados Hiperémios del Tegido Cavernoso de los Cornetes Nasales Inferiores.) *Revista de Laringología, Otol. y Rinol. Barcelona, December, 1886.*

THE author has examined 537 individuals with various complaints of the air-passages, and has found in 342 hypertrophy of the cavernous network covering one or both turbinated bodies; so marked as to be without doubt the principal cause of the pathological symptoms, or a sufficient hindrance to recovery of health.

RAMON DE LA SOTA Y LASTRA.

**CHEATHAM** (Louisville).—Naso and Naso-Pharyngeal Reflexes. *New York Medical Record, July 17, 1886.*

ELECTROLYSIS is recommended by Dr. Cheatham for the reduction of nasal hypertrophies, as being rapid, efficacious, and much less dangerous than the galvano-cautery or the acids. The after-effect is much more satisfactory, there being no cicatrix left except at the point of entry of the needles. Cocaine is used to differentiate between hypertrophy and engorgement. The author locates sensitive areas in some cases in the larynx, pharynx, and conjunctiva. He also refers to the frequency of trigeminal cough and its proper management. He also divides the causes of hay fever into—(1) External irritation; (2) Predisposition; (3) Vulnerable or sensible area. He recommends to find this latter and destroy it.

**BRYER, T. H.** (Edinburgh).—Case of Chronic Poisoning by Bisulphide of Carbon. *Edin. Med. Journal, August, 1886.*

AMONGST the symptoms was partial anosmia after exposure to the vapour.

HUNTER MACKENZIE.

**HALL, DE HAVILLAND** (London).—On the Treatment of Sneezing, Hay Fever, Asthma, &c., by the Galvano-Cautery. *Lancet*, No. XX. Vol. II. *November 13, 1886.*

A CASE, typical of the class of case in which the author would use the galvano-cautery. The patient suffered during pregnancy from violent fits of sneezing, and for three or four years had suffered from hay fever which lasted a month. The mucosa over the inferior turbinated bone (right) was greatly hypertrophied, and somewhat less so over the left. Two applications of the cautery were made, consisting of two or three deep furrows. The patient experienced "very great improvement," though the sneezing attacks recurred about four

times daily, but were arrested by inhalation of carbolized smelling salts. The author cites a case of sneezing, nasal flux, and asthma, which was cured by internal administration of citrate of caffeine and bromide of potash, and another case of excessive sneezing, which was cured by syringing the nose with carbolic acid, borax, and bicarbonate of soda. The author has great faith in the use of carbolized smelling salts.

**COZZOLINI, V.—Primary Lupus of the Nasal Mucous Membrane.**

*Archivii Ital., An. VI., Fas. 1 e 2.*

THE author gives clinical observations he has completed on five patients with primary lupus of the nasal mucosa in the period of five months.

He begins with an historical survey, lamenting the small attention given by observers, and the poverty of the literature in contrast to that given to primary lupus of the pharynx, fauces, and larynx, which are, in his belief, less frequent than that of the Schneiderian membrane. He then speaks of the general symptomatology of nasal lupus, holding with the opinions of modern authors, and he considers as its characteristic sign the great accumulation of grey or dirty yellow crusts which overlies one another like tiles,—there being no pathognomonic odour,—no less than the tendency of the process to localize itself on the cartilaginous septum. Afterwards he proceeds to discuss the histology and pathology of lupus, holding that histologically it is a granulation-neoplasm, distinct from other granulomata, and, from the bacteriological point of view, he regards it, with Volkmann, as a modification of tuberculous infection of the skin and mucous membrane. The clinical form predominating in the Schneiderian membrane is lupus vulgaris. The author believes that if lupus is not to be considered exclusively as a manifestation of scrofula, yet clinically we must admit that the latter is an almost necessary condition of its development. As for the relation of syphilis to lupus, with regard to which many authors, according to Giovannini, hold that a great number of cases of lupus are the result of hereditary syphilis, the author believes this to be a false assertion, if it is to be taken without reservation, but not if it is to be considered only that the syphilis facilitates the development of the scrofula, and that the two diseases influence each other reciprocally. There is a certain resemblance between lupus and syphilis from the anatomico-pathological point of view, although Kaposi maintains that the nodules are distinguished biologically in an essential manner, but still more from the clinical point of view.

Finally, the author speaks of the cure. He objects to internal

treatment, seeing that it has never afforded appreciable results, and relies on local methods grounded on all those means which destroy, mechanically or chemically, the lupus elements; among which he prefers the method of interstitial cauterization with the galvano-cautery, and sometimes the thermo-cautery. He does not overlook, however, disinfection of the nasal fossæ. The conclusions which close the article repeat, although with some pretension, its principal points.

The ages of his five patients are scarcely mentioned by the author, while the special form, the locality, and intensity of the lupoid process are not described. The reader would rather have nasal lupus presented to him as seen in the patients, than an abstract account of the pathological history, which, moreover, was already sufficiently understood.

MASSEI.

## TONSILS, PHARYNX, &c.

**BOTTINI.**—Tonsillotomy and Two Cases of Malignant Tumours of the Tonsils. *Gaz. degli Osp.*, An. VII.—43.

MASSEI.

**LABORDERIE,<sup>1</sup> DUBOUSQUET.**—Infectious Amygdalitis. (Des Amygdalites Infectieuses.) *Congrès de Nancy*, 1886.

A PATIENT, enfeebled from any cause, is seized with sore throat, shivering, fever, prostration, headache, &c.; swelling of the throat, pain on deglutition; the ganglia of the neck are swollen and painful; the urine is albuminous, and contains bacteria. The treatment should be antiseptic, especially using quinine and resorcin. An emetic is useful at the commencement, and tonics during the course of the disease. Hypertrophied tonsils are to be removed as a preventive against future attacks.

JOAL.

**GIMENER, VALERA Y.**—Angina Parenquimatosa Crónica. Tratamiento con el Termocauterio-Curación. (Chronic Phlegmonous Sore Throat. Treatment with the Thermocautery Cure.) *Revista de Laringol. Otol. y Rhinología*. October, 1886.

THE title explains Gimener's case.

RAMON DE LA SOTA Y LASTRA.

**SPENCER, H. R.** (London).—Pharyngeal and Laryngeal Nystagmus. *Lancet*, October 9, 1886.

IN a girl of twelve, with cerebral tumour and ocular nystagmus, the author observed constant rhythmical movements of the superior pharyngeal constrictor, the soft palate and fauces not being affected.

The movements were of the same rate as the ocular nystagmus, *i.e.* 180 a minute. The laryngeal muscles are similarly affected, the arytenoids gliding to and fro, synchronously with the pharynx. Widening of the glottis during inspiration is interrupted by slight twitches, and when breathing stops the cords close with five or six contractions until they lie parallel and close to each other. Here they remain, with only slight tremor, until the patient commences to breathe again. The observation is new.

**SOMMERBRODT** (Breslau).—**Ueber im Pharynx Localisirte Hydrargyrose. (Localised Hydrargyrosis of the Pharynx.)** *Berlin Klin. Woch.*, No. 47, 1886.

SCHUMACHER has observed in the pharynx of patients undergoing mercurial inunction changes which he attributed to the drug, even when stomatitis and affections of the gums were absent. He differentiated an acute and chronic form. Sommerbrodt relates the case of a professional engaged in the practice of inunction, and not himself syphilitic, who for eight days had suffered from pains in the neck on swallowing. There was no swelling of the mouth, fœtor, or salivation, but the frenulum epiglottidis, right margin of the epiglottis, and right glosso-epiglottidean fold, were swollen and reddened, with small, round, oval, superficial, white and sharply-defined ulcers on their surface. The mucous membrane extending from the epiglottis to the pharynx was also reddened, and on the lowest portion of the hind wall of the pharynx was a large number of white round plaques, resembling aphthæ, the surrounding mucous membrane being reddened. The larynx was unaffected. Schumacher had seldom seen this condition of the lower part of the pharynx in his patients. It is at this spot that the saliva accumulates. This condition should be found in persons working in mercury, such as mirror-silverers, &c.

**NYKAMP** (Leiden).—**Pharyngo-Mycosis Leptothricia.** *Nederlandsch Tydschrift voor Geneeskunde*, 1886, p. 406.

CASEOUS matter, containing leptothrix, is often found in the crypts of the tonsils. The two cases described by the author are rather remarkable. In the first, greyish spots were found on the tonsils, the pharynx, and in the membrana interarytænoidea, and a slight paresis of the left vocal cord was produced. After treatment, partly galvano-caustic, and partly by painting with 10 per cent. chinoline solution, the patches disappeared totally. In the second case a grey spot on the posterior side of the epiglottis was found occasionally, in a medical student practising laryngoscopy. Greyish patches, consisting of leptothrix, were found between the papillæ circumvallatæ



on the back of the tongue and on the epiglottis, without anything on the tonsils or pharynx. The patient did not complain of anything.

GUYE.

**ARIZA, RAFAEL.**—*Acute Tubercular Pharyngitis. (Faringitis Tuberculosa Aguda.)* *Revista de Medicina y Cirugia Prácticas.* December, 1886.

ARIZA refers to the case of a young physician, delicate, aphonic, and suffering from the greatest odynphagia. Several small red outgrowths, springing from an ulcerated base, were located on the anterior pillars of the fauces, while in the pharynx were two or three whitish granules of the size of a pin's head, and another on the base of the uvula. None of these granulations had the characteristic yellow colour. The patient had experienced three attacks of "sore-throat" within a few months, but described himself as having been perfectly well since the last. Ariza diagnosed acute tubercular pharyngitis, though the appearances were not typical of this condition as described by Isambert and others. Tubercule-bacilli of recent origin were abundant. Ariza infers from this case, that (1) acute miliary pharyngitis is rare; (2) the course of the complaint, described as continuous and ending in death, can have exceptions; (3) the possibility that the appearance in different localities of the lesions may not correspond in point of time to the classical descriptions which have been given; (4) it is curable.

RAMON DE LA SOTA Y LASTRA.

**FOX, LONG (Bristol).**—*Case of Dysphagia accompanied by Ascites.* *British Medical Journal*, January 15, 1887.

A CLERGYMAN, aged thirty-five, was said to have had symptoms suggesting gastric ulcer, not, however, severe. During convalescence sudden dysphagia supervened, without hæmorrhage or vomiting of mucus. He could take plenty of liquid food, allowing long intervals between swallowing. An obstruction in the œsophagus being met with, and the patient being further much emaciated and also sallow-complexioned, a physician who saw him in the spring diagnosed cancer of the œsophagus. In the summer of the same year he began to have fluid in the abdomen, soon followed by some anasarca of the lower extremities, without albuminuria, or any tangible change in the liver itself. On December 1, a half-gallon of fluid was evacuated from the abdomen, and from this time the ascites gradually diminished. Ability to swallow solids returned, slowly at first, but was eventually completely re-established. The patient also recovered general health. Against the diagnosis of malignant disease were:—1st, the sudden onset of dysphagia; 2nd, the absence of blood

and mucus from the œsophagus ; 3rd, the absence of pain when the œsophagus was distended with large quantities of fluid ; 4th, the co-existence of ascites, showing that the pressure on the œsophagus was from without that organ, in the face of the fact that cancerous glands in the mediastinum are very rare, except as secondary to cancer elsewhere ; 5th, the good result was largely due, probably, to the administration of iodide of potassium. There could be no reason to suspect syphilis in this case. It is thought by Dr. Fox that an enlarged gland pressed upon the gullet, and also upon an important channel for conducting the blood from the lower extremities to the heart, *i.e.*, the inferior vena cava.

**JACOBI** (New York).—**Multiple Strictures of the Œsophagus: Gastrostomy.** *New York Medical Record*, July 31, 1886.

A LABOURER swallowed spirits of ammonia ; dysphagia resulted. Nine months afterwards the smallest bougies could not be passed into the stomach. Gastrostomy was performed, and the patient died of exhaustion after the operation. Three strictures were found post mortem at varying distances, and below the first stricture a sub-mucous pouch. Below the second stricture, and five centimètres above the lowest stricture, were found two openings leading into a long suppurating cavity which passed behind the last constriction and opened into the stomach below it. The case illustrated the danger of using œsophageal bougies, however carefully. Dr. Jacobi further illustrated this point by the relation of a case where a bougie had been passed daily on a baby, and though it appeared to be doing perfectly well, and swallowed whisky and milk, it suddenly developed pleurisy and died. It was found post mortem that the bougie had broken through the mucous membrane, leaving a fistula, which increased in size, and finally perforated into the right pleural cavity, setting up intense pleurisy.

**BERNS** (Amsterdam).—**Two Cases of Œsophagotomy for the removal of Artificial Teeth.** *Nederlandsch Tydschrift voor Geneeskunde*, December 4, 1886.

BOTH cases were very successful. In the first, a man, aged thirty-five, had swallowed, while asleep, a set of two artificial teeth. Great tenderness about the cricoid cartilage. The operation was performed on the same day, and in a fortnight the patient left in perfect health. In the second case, a young lady, aged nineteen, had swallowed, in a hysterico-epileptic fit, a plate containing three teeth, and having a rather sharp ring which had fitted over another tooth. Owing to the irregular form of the foreign body, the extraction caused a little

more laceration of the œsophagus than in the preceding case, and there was for some time a consecutive abscess, which finally was quite cured. The author finds the mortality in 42 cases which he found recorded amounting to 10, *i.e.*, 23·8 per cent. His opinion is, that this high mortality is not the result of the danger inherent to the operation, nor even to the length of time during which the foreign body has remained in the œsophagus, but that it is more probably due to the injury done to the œsophagus by the sharp and irregular form of the foreign body, especially when efforts at extraction have been continued for some time. He accordingly advises great prudence in this respect, and to operate as soon as possible.

GUYE.

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## LARYNX.

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**KOCH, PAUL.**—Influence of the Laryngoscope on the Diagnosis of Extra-Laryngeal Affections. (*Influence du Laryngoscope sur le Diagnostic des Affections Extra-Laryngiennes.*) *Read before the French Association for the Advancement of Science, Nancy, 1886.*

THE author opens his address by reminding his hearers that rational therapeutics depends upon diagnosis, and that the number of symptoms necessarily increases with our means of investigation. While admitting that the treatment of laryngeal affections belongs to the specialist, he proceeds to point out how the laryngeal mirror renders great service in the diagnosis of general maladies. After referring to phthisis, Dr. Koch asserts that laryngeal ulceration is much more frequent in typhoid fever than is generally supposed, and that the diagnosis of it, as distinguished from purely nervous troubles, is of the highest importance. After reviewing in this connection such diseases as syphilis, small-pox, erysipelas, &c., the author passes on to acute articular rheumatism. Here the crico-arytenoid articulations are only exceptionally affected; but a laryngeal dyspnœa is explained by the discovery of round, painful swellings over the arytenoid cartilages. Next he reviews the various cervical and thoracic affections which may cause pressure on the recurrent laryngeal nerves. Passing on to the consideration of nervous affections he adverts to the frequency of laryngeal neuroses in locomotor ataxy, and refers to cases where the laryngoscope was the means of initiating a correct diagnosis. Finally, the author reviews hysterical affections; he asserts that they can be explained only on the assumption of cortical motor centres, and that they appear to confirm the

observations of Horsley and Semon, according to whom the centres are bilateral and independent of the centre of speech, which is only unilateral.

GREVILLE MACDONALD.

**BRUCE** (Bristol).—**The Laryngoscope in Medicine.** *Bristol Medico-Chirurgical Journal*, Vol. IV. No. 13. September, 1886.

NOTHING new.

**NUVOLI.**—**Tracheotomy.** *La Riforma Med.*, No. 223, September 27, 1886.

At a meeting of the Società Lancisiana degli Ospedali di Roma, Dr. Nuvoli referred to an urgent tracheotomy, a bistoury being the only instrument available. The index finger in the tracheal incision sufficed to keep it open.

MASSEI.

**LUNN** (Hull Royal Infirmary).—**Scald of the Larynx in a Child; Tracheotomy; Recovery.** *Lancet*, December 18, 1886.

THE title indicates the nature of the case.

**PAULY** (Posen).—**The Causes of Granulation Stenoses after Tracheotomy.** (*Die Ursachen der Granulationsstenosen nach Tracheotomie.*) *Deutsche Med. Wochens.*, No. 44, 1886.

A GOOD review of the literature of the subject.

MICHAEL.

**HANCE, N. H.**—**Intubation of the Larynx.** *New York Medical Journal*, October 2, 1886.

THIS paper is a report of cases of membranous croup treated with O'Dwyer's tubes. The author prefers the tubes to tracheotomy for the following reasons :—

#### INTUBATION OF THE LARYNX.

The tubes produce no shock during introduction.

They are instantaneously introduced.

They are easily introduced.

They cause no wound.

They clean themselves.

The inspired air is warm and moist.

There is no increased risk of a complicating pneumonia.

There is no after treatment.

#### TRACHEOTOMY.

Tracheotomy sometimes produces fatal shock.

It requires from ten to thirty minutes to open the trachea.

It is often a very difficult operation, especially in a child of from four to six years of age.

It leaves an extensive wound liable to diphtheritic poisoning, &c.

It requires constant care to keep the inner tube clean.

Artificial means are necessary to make the air warm and moist.

The escaped blood and other fluids into the trachea increases the risk of pneumonia.

The wound requires to be treated after the removal of the tube.

**BOUCHUT.**—On Intubation of the Larynx. (*Sur le Tubage du Larynx.*) *Gazette des Hôpitaux*, November 30, 1886.

REFERRING to recent literature, Dr. Bouchut relates the fact that nearly twenty years ago he, being then struck with the terrible inefficiency of tracheotomy, sought some means of replacing this operation, and read at the Academy of Medicine (in 1858) a memoir "On a New Method of Treating Croup by Tubage of the Larynx." He there sought to prove that it was easy to practise tubage of the larynx by means of a canula fixed on the vocal cords, and not interfering with the functions of the epiglottis. He added that it was possible to remedy in this manner the asphyxia of croup and other affections of the larynx, and that this method was to be preferred to tracheotomy. Trousseau then formulated this conclusion—Tubage cannot replace tracheotomy except in rare instances, and this is the principal means of dealing with croups in which other medical treatment has failed. Bouchut's communication was treated curiously as an unpatriotic attempt to depreciate a method of treatment "entirely French," and the discussion which followed took the character of a veritable "execution." Recent publications have proved that the Academy was wrong, and that Bouchut was right. JOAL

**NEWMAN, D.** (Glasgow).—Case of Excision of the Larynx for Malignant Disease. *Glasgow Medical Journal*, November, 1886.

EXHIBITION of patient before the Glasgow Pathological and Clinical Society, May 11, 1886, with details of the method of operating employed. The result has so far been highly satisfactory.

HUNTER MACKENZIE.

**BROWNE, L.**—Excision of left of the Larynx for Epithelioma; Recovery. *Medical Press*, December 22, 1886.

THE disease was extensive, involving the left vocal cord, and originating in the ventricle, and causing dyspnoea of eighteen months' duration. Tracheotomy having been performed, and Hahn's canula introduced, the major operation consisted in the separation of the perichondrium with the raspator, and the removal of half of the thyroid and cricoid cartilages, and the whole of the arytenoid, but leaving the superior cornu intact. Only two arterial twigs required torsion, and the oozing was checked by the galvano-cautery. The tracheotomy tube was removed at the expiration of seventy-two hours, and six hours later he ate a mutton chop. On Christmas Day, the eleventh from the operation, he had turkey and champagne for dinner. On the thirteenth day his pulse was 80; temperature 98·8 degrees.

GREVILLE MACDONALD.



**HOFMAN** (Wien).—Zur Kenntniss der Entstehungsursachen von Kehlkopffracturen. (Contribution to the causes of Fracture of the Larynx.) *Wien. Med. Woch.*, No. 44, 1886.

CASES seen by the author :—

1. Longitudinal fracture of the thyroid, and the posterior cornua, by a blow from a hatchet.
2. Fracture of the larynx from treading on the neck.
3. Laceration of the neck and multiple fracture of the larynx by the traces of a steam machine.
4. Multiple fractures of the larynx from a heavy stone.
5. The same from squeezing by a carriage.
6. A similar case.
7. A cutting wound of the neck made with a dull knife, both posterior cornua being fractured, without being cut, by forcible pressure against the vertebral column.

The author has seen four cases in which the fracture (of the larynx) was caused by falls on the head. The author concludes—

1. Fractures of the larynx, especially of the cornua majora and the cricoidea, can be caused by a direct force, especially if the cartilages have lost their elasticity.
2. They may also be caused by indirect force, compression, or traction.
3. Cutting of the throat with a dull instrument, or falls on the head, may also cause fracture.

MICHAEL.

**FRAENKEL**, B. (Berlin).—Erste Heilung eines Larynxcancroids mittelst Ausrottung per vias naturales. (First Cure of a Laryngeal Cancer by Extirpation per vias naturales.) *Langenbeck's Archiv f. Chir.*, Bd. xxxiv., Heft 2.

A PATIENT, seventy years of age, had a tumour on the right vocal cord of the size of a bean. This was extirpated by the cautery loop. Microscopically it proved to be a carcinoma. A year later it recurred, and was extirpated in the same manner. Two years afterwards it recurred, and was again extirpated. During the next three years, three returns, with extirpation after each. A carcinomatous gland of the neck was also removed by Professor Madelung. The patient is now seventy-five years of age, and for two years the larynx has shown no sign of any neoplasm. The voice is clear and loud. (This is a triumph of intra-laryngeal surgery.)

MICHAEL.

**CHARLES**, D. H. — Œdematous Laryngitis; Tracheotomy; Glossitis, terminating in Abscess; severe Hæmorrhage from Tongue; Recovery. *Brit. Med. Jour.*, November 6, 1886.

THE case is stated to be one probably of contiguous œdematous

laryngitis. The laryngoscopic appearances were: "epiglottis very much thickened, and of a deep red colour . . . false cords also swollen and inflamed." A solution of nitrate of silver (f. ʒj. ad ʒj.) gave temporary relief to the dyspnœa; but ultimately laryngo-tracheotomy was performed under great difficulties. On the night of the operation the tongue was normal, while sixteen hours later it filled the mouth, the only assignable cause of the inflammation being extension from the epiglottis. Abscess formed, which on the fifth day opened spontaneously. Five days later alarming hæmorrhage set in, the source of which was not ascertainable, but which, although returning three or four times, yielded to astringents. The patient ultimately recovered, with wasting and partial loss of power in the tongue, which the author ascribes to degeneration of the muscular tissue.

G. MACDONALD.

**PRIM, BASSOLS** (Barcelona).—*Laringopatica Sifilitica no Ulcerada.* (Laryngeal Syphilis without Ulceration.) *Revista de Laring. Otol. y Rinologia.* October, 1886.

THE author relates a case showing that there are laryngeal syphilitic cases which do not yield to antispecific treatment. They last a long time, undergo exacerbations on the slightest provocation, as occurs in catarrhal laryngitis, and need, therefore, every precaution.

RAMON DE LA SOTA Y LASTRA.

**MACKENZIE, HUNTER** (Edinburgh).—*Chronic Laryngitis and its Sequelæ.* *Edinburgh Medical Journal*, January, 1887.

THE author directs attention to the propriety of not overlooking the fact that a neglected chronic laryngitis may drift into tubercular disease, or into the domain of distinct tumour-formation. In regard to the diagnosis of the former, he says it is frequently impossible to say by mere laryngoscopic examination when this degeneration has taken place; recourse must be had to the microscopical examination of the sputum for the bacilli of tubercle. The presence of elastic tissue in the sputum is misleading as an indication of tubercular disease either of the larynx or lungs. He holds that tubercle, first of the larynx and subsequently of the lungs, may be one of the sequelæ of chronic laryngitis (see confirmatory case, "Case of Laryngeal and Pulmonary Tuberculosis originating in Simple Chronic Laryngitis," *Lancet*, February 14, 1885). With reference to the formation of growths or tumours and their treatment, he cites a case of papillomatous disease of the larynx as a result of chronic laryngitis after measles, in which the performance of tracheotomy and the wearing of the canula not only relieved the breathing, but ultimately,

without further treatment, effected the removal of the growth, and the restoration of the voice. He accounts for this by the rest and freedom from irritation afforded to the larynx by the performance of the operation, and he thinks it worthy of consideration whether this plan should not be adopted in all cases which evince a tendency to tubercular degeneration, or to the formation of distinct growths.

Attention is also directed to the fact that chronic inflammation may complicate or accompany the specific lesions of the larynx, *e.g.*, cancer, and unless great care be exercised, may render fallacious the results of microscopical examination of the pieces of the neoplasm which have been artificially or spontaneously discharged during life.

HUNTER MACKENZIE.

**CHARAZAC** (Toulouse).—**Contribution to the Study of Gummata of the Larynx.** (*Contribution a l'Etude des Gommages du Larynx.*) *Rev. Med. de Toulouse, October, 1886.*

GUMMATA of the larynx occur oftenest among men. They are met with under the infiltrated or ulcerating form. In the first form, the lesion is circumscribed or diffused; the subjective symptoms in these cases consist in troubles of respiration, phonation, and deglutition. The respiratory troubles vary with the extent of the swelling; affection of the voice, hoarseness, and dysphagia occur only when the epiglottis is infiltrated. Pain is rare, but that it does occur sometimes the author relates an example. Laryngoscopic examination determines the seat, extent, and period of evolution of the gummata. Ulcerated gummata are of graver import than the infiltrated form, and the diagnosis is more difficult. Dr. Charazac studies the symptoms which differentiate gummata from phthisis, cancer, hypertrophic laryngitis, leprosy, and lupus, ending with some remarks as to treatment.

JOAL.

**CARTAZ, A.**—**On Crico-Arytenoid Arthritis at the commencement of Tubercular Laryngitis.** (*De l'Arthrite Crico-Arytenoidienne au début de la Tuberculose Laryngée.*) *France Médicale, November, 1886.*

A CERTAIN number of so-called paralyzes of the vocal cords are simply the result of defective mobility of the cartilages, and not of any direct nervous lesion, compression, or alteration of the intrinsic muscles of the larynx. Tuberculosis seems to be one of the conditions in which crico-arytenoid arthritis may supervene the most frequently. Tubercular laryngitis very constantly shows its first

alterations in the arytenoid region, and it is with these primitive lesions that Cartaz occupies himself. This author relates two cases in which crico-arytenoid arthritis and a consecutive ankylosis were the first manifestations of tuberculosis. This was brought about in the following manner: at first, tubercular infiltration in the region of the cricoid and arytenoids, which led to perichondritis, then inflammation of the cartilage and the articular surfaces, and finally to pseudo-ankylosis. The diagnosis of ankylosis, unilateral or bilateral and of the different vocal paralyses, is very often most difficult; but there are two signs which may be taken to indicate a lesion of the articulation, viz., pain localized over the articulation, especially in transmission of the voice, and tumefaction of the arytenoid region.

JOAL.

**TRIFILETTI, A.**—On the Value of Clinical Diagnosis in a Case of Paralysis of the Adductor of the left Vocal Cord. *Archiv. Ital. di Laring., An. VI., Fasc. 3 and 4.*

THE author wishes to point out the no small difficulty sometimes attending the differential diagnosis, anatomical as well as etiological, between paralysis of the abductors and that of the adductors. He first regards the question from the side of anatomical diagnosis, and discusses, as causes of the difficulty, the simultaneous action of the two muscular groups, and the small space in which the lesion is included, no less than the gradual development of the special paralysis; he then speaks of the etiological diagnosis, and considers that many lesions of internal organs, in their early stages, are not appreciable by physical examination, that at the same time it is common to assume the action of remote causes, through which are produced paralysis equally of the abductors and adductors, and that finally a central nerve lesion or pressure on the recurrenents may induce indifferently either of the two paralyses.

From this he infers that to obtain an exact diagnosis, one must estimate both anatomical and etiological observations, making them agree with the results of practical medicine. In fact, he summarizes in clinical order, the bearings on the differential diagnosis between the two groups of muscles, and applies his remarks to a case observed in the Clinical Hospital of Naples. He relates the history and objective examination of the patient. Summarizing all the data, anamnestic, etiological, anatomical, curative, and clinical, he was enabled to establish a diagnosis. The article is written with a marked precision of detail, although the purely clinical aspect is somewhat faulty.

MASSEI.

**PRAMBERGER** (Graz).—*Laryngologische Studien. (Laryngological Essays.)* *Deutsches Archiv für klin. Med., Bd. xxxix., p. 259.*

1. *Case of Tuberculosis* with especial implication of the under parts of the cornua laryngis. The author makes the very true remark that large granulations in the posterior part of the interarytænoid region are very often seen in patients whose aspect and whole constitution would lead us to expect tuberculosis.

2. *Syphilitic Affection of the Larynx* with gummata and ulcers.

3. *Epithelioma of the Pharynx.* The patient, thirty-eight years old, had had syphilis fourteen years previously. He complained of hoarseness and dysphagia. In the lungs was found consolidation of the right apex. In the deeper parts of the pharynx on the right side, a large ulceration was seen with the laryngoscope. No enlarged glands. Iodide of potassium and mercury were exhibited without effect. After two months the patient died of consumption. The autopsy revealed carcinoma of the pharynx, and tuberculosis of the left lung.

4. *Primary Epithelioma of the Larynx.* Case without special interest.

5. *Paralysis of the Right Cricoarytеноideus Posticus.* These cases are not seen very often, because unilateral paralysis does not produce any symptoms. This patient came under treatment only for pharyngitis granulosa. The voice was sometimes hoarse, and always rather deep. The etiological factor was enlarged cervical glands.

MICHAEL (Hamburg).

**PILTAU.**—*The Influence of Respiration on Singing, and the Passive Tension of the Vocal Cords. (De l'Influence de la Respiration dans le Chant, et de la Tension Passive des Cordes Vocales.)* *Tribune Medicale, October, 1886.*

EXPERIMENTS made in the laboratories of Paul Bert and Marey, lead the author to the following conclusions:—

1. That the absolute velocity of the shock of air in vocal expiration rules the height of the sound.
2. The magnitude of the pressure variations of the subglottic column of air rules the intensity of the sound.
3. The regularity of the expiratory air current determines the clearness of the sound.
4. The "chest voice" is the result of a pressure sufficient to give complete shock to the inferior vocal cords.
5. The "head voice" is obtained by a low intra-tracheal pressure.



6. The "timbre" of the voice depends upon the lowering of the larynx, and epiglottic, pharyngeal, buccal, and nasal modifications. JOAL.

**PARKER, R. W.**—Endo-Tracheitis and Endo-Bronchitis. *Transactions Path. Soc. Lond., Vol. xxxvii., 1886.*

THE account of the case was interesting, both from the nature of the lesion and its extent. The change was essentially endo-tracheal, and, probably, also primarily endo-bronchial. In the trachea the pathological process was confined to the interior of the tube, but in the lung there were extensive peri-bronchial changes. The author regarded these as secondary, and set up by retention of the secretions. The calibre of the trachea was reduced to one-third of its normal size, while the left bronchus was almost completely occluded. It was remarkable how little dyspnoea there was until within a few days of death. The patient was a boy of fifteen years.

GREVILLE MACDONALD.

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## NECK, &c.

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**HORSLEY, V.**—The Pathology of the Thyroid Gland. *The Brown Lectures (delivered at the London University), Lancet, December 18, 1886.*

THE lecturer suggested that, probably, the thyroid gland is "hæmapoietic as the result of some metamorphosing influence it may have on the fluid constituents of the blood." Recognising the accuracy of Wooldridge's recent observations, that the mere action of cold upon corpuscle-free blood-plasma could produce a precipitate of biconcave discs, it might be further suggested that the thyroid gland may possess a cytopoietic function in an indirect fashion, blood discs being precipitated from the fluid blood-plasma, by some method as yet unknown. Such a process might be part of the hæmapoietic function of the gland.

Next, discussing the histology of the gland, Mr. Horsley referred to the lump of embryonic tissue which exists in a large quantity, in some animals, separately and distinctly encapsuled. The lecturer did not accept Virchow's view that this could be the homologue of a single acinus, research having tended to negative the view that this embryonic tissue could ever develop into acini. Of the nature of the large parenchymatous cells described by Weber, we are also in

the dark. These nodules are not only imperfect developments of the thyroid gland, since they increased in size, number, and staining power, when the thyroid gland underwent development in consequence of the removal of one lobe. Mr. Horsley next discussed the "compensatory hypertrophy" of the kidney, and showed that if the actual body-weight did not increase, and if there was actual loss of weight, then the "compensatory hypertrophy" of the remaining kidney did not occur. In hypertrophy of the thyroid, the acini were remarkably changed, the lining epithelium multiplied in number, and increased in size, so that a plication of the wall results. There is no increase in the number of Weber's cells, and no metamorphosis of the "embryonic" tissue into acini. The colloid material of the acini does not increase in amount, but becomes softer, more viscous, and less solid. Increased activity, therefore, caused a diminution in the consistence of the organ, in contrast to the solidification that occurs of the acinal contents, when the organ is less active.

In the second lecture, Mr. Horsley discussed the relation of the gland to the encephalon, the innervation of the gland, and its comparative pathology. The lecturer believed that, in spite of the views entertained as to the connection with the cerebrum, the relation was more apparent than real, and brought forward experiment to show that removal of one lobe of the thyroid exerted no influence over the nutrition of the motor cerebral centres of the same side. He would only tentatively adopt the German view, that the gland had any special metabolic function over those waste products which are especially inimical to the nervous system, and particularly the brain. The lecturer stated that there was no evidence, experimental or clinical, to show that the thyroid gland is represented in the cerebral hemispheres. Mr. Horsley believed that the gland was chiefly supplied by sympathetic nerves, and that the sympathetic was the secretory or glandular nerve. With regard to the relation of the recurrent laryngeal nerve to the gland, he had made two experiments, excising in two dogs a portion of the recurrent nerve, but after several months there was no histological difference in the gland. Schiff's experiments were incomplete as regards the sympathetic, as he did not keep his animals alive for a sufficient time.

Mr. Horsley, speaking of the comparative pathology of the gland, said that he had obtained sufficient experimental evidence of the fact that the gland possessed a very different activity in different animals, both anatomically and pathologically. The greater the activity of the gland in any particular animal or class of animals, the more urgent and rapid were the symptoms that followed its removal,

and conversely. The suggestion was made that where the glands and acini are small, the functional activity is least. These lectures, and the experiments on which they are founded, are a most valuable contribution to a very difficult chapter of pathology, and are full of suggestion.

**ORMBY.**—**Exophthalmic Goître, Angina Pectoris, Hysteria.**  
(*Goître Exophthalmique, Angine de Poitrine, Hysterie.*) *Lyon Medical, January 9, 1887.*

OBSERVATIONS on a patient presenting these three symptoms, which he thinks sufficiently rare, since the classical works of Huchard, Marie, &c., do not mention such a combination. JOAL.

**HEYDENREICH.**—**The Interglandular Enucleation of Goître.**  
(*L'Énucléation Interglandulaire du Goître.*) *Semaine Médicale, January 12, 1887.*

THE author, in describing this method (advanced by Socin, *Cent. f. Chir.*, November 6, 1886), says that this operation does not lead to cachexia strumipriva, because it consists only in the removal of the degenerated parts, thus permitting the healthy portion of the gland to continue its functions. Heydenreich draws attention to a new point. After ablation of the thyroid body, there is sometimes remarked a flattening of the trachea, with a tendency to occlusion during respiratory movements, thus producing asphyxia. It is probable that this condition arises from the fact that the trachea is flattened by the pressure of the goître, like a sabre scabbard, and loses by the extirpation of the gland the props which maintain it open. Enucleation, which respects the healthy portion of the gland, leaves in position these natural supports, and cannot therefore be exposed to these accidents. JOAL.

**WENILECHNE, R. (Wien).**—**Ligature of the Superior Thyroid Artery for a Struma.** (*Unterbindung der Arteriae Thyroidae Sup. wegen eines Kropfes.*) *Session of the k. k. Gesellschaft der Aerzte in Wien, November 5, 1886.*

THE patient was thirty-three, and had a large struma. The great dyspnœa prevented extirpation. The artery was therefore ligatured as proposed by Wölfler. The struma became subsequently much smaller, and the dyspnœa was cured. MICHAEL.

**COLLINS.**—**The Relation of Insanity to Exophthalmic Goître**  
*Lancet, January 8, 1887.*

A CASE is narrated of this complaint, in which the patient developed melancholia with delusions, and persistent refusal of food necessitated

feeding with the stomach-pump for one month. This subsequently subsided, leaving the palpitation, exophthalmos, and goitre *in statu quo*. No family record of insanity or epilepsy, &c., could be obtained.

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**KELLY, A. L.** (Glasgow).—**Two Cases of Lymphadenosis.** *Glasgow Medical Journal*, December, 1886.

A COMMUNICATION to the Glasgow Southern Medical Society, March 11, 1886. In one of the cases (a male, aged twenty-three years) several large glandular swellings were present in the right side of the neck, reaching in a chain-like form from the angle of the jaw to the clavicle; similar swellings were present in the left arm-pit, and also in both groins. The enlargements were all hard, and none of them had suppurated. The patient had been lost sight of, and the course of the case was therefore unknown.

In the discussion which followed, Dr. Park remarked upon the good results which he had seen follow the injection of such tumours with ten-minim doses of the tincture of iodine.

HUNTER MACKENZIE.

**CARMICHAEL, JAMES** (Edinburgh).—**The Bronchial Catarrh of Children.** *Edinburgh Medical Journal*, October and November 1886.

THE author recognizes this disease as often beginning with a coryza, and as spreading by continuity of surface to the tracheal and bronchial mucous membrane. He believes that nasal, laryngeal, tracheal, or bronchial stenosis will produce pulmonary collapse; hence its occurrence in croupous or diphtheritic laryngitis, and in laryngismus stridulus. In young children, in fact, stenosis of the nares often plays an important part in the production of collapse of the lung.

The communication, as a whole, is of more interest to the general physician than to the specialist.

HUNTER MACKENZIE.

**PHILIP, R. W.** (Edinburgh).—**An Improved Method for the Detection of the Tubercle Bacillus in Sputum.** *Edinburgh Medical Journal*, November, 1886.

THE principle of this method is essentially one of concentration, this being obtained by a double process of incubation and precipitation or deposition. By collecting the sputum of from twelve to twenty-four hours, and exposing it in a beaker or flask to the influence of a gentle, moist heat for twenty-four hours or longer, it will be found that the heavier cell elements have separated, and

become deposited at the bottom of the vessel. A drop of this deposit may be removed by a pipette; it no longer has a cohesive character, and, consequently, may be spread with much greater ease and exactness on the cover glass. Staining and mounting are done according to any of the approved methods. Under the microscope, bacilli are found in relatively increased number, owing, according to the author, to (1) the precipitation and resulting concentration, and (2) to an absolute increase in numbers of the bacilli, this latter being due to the process of incubation in a favourable soil (sputum).

HUNTER MACKENZIE.

**COATS, JOSEPH** (Glasgow).—**The Vesicular Murmur in Respiration.** *Glasgow Medical Journal*, November, 1886.

A COMMUNICATION to the Glasgow Pathological and Clinical Society, May 11, 1886, on Dr. Newman's case of excision of the larynx, with special reference to the origin and propagation of the laryngeal and pulmonary auscultatory phenomena. The conclusions arrived at were—First, the sounds produced at the glottis or larynx are freely conducted by the dense tissues comprising the trachea and bronchi; secondly, the vesicular murmur takes origin in the extreme distal part of the respiratory apparatus.

HUNTER MACKENZIE.

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## REPORTS OF SOCIETIES.

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### Pathological Society of London.

At a meeting held on October 19,

MR. F. TREVES read notes and showed microscopic specimens of three cases of *Malignant Cysts of the Neck*. The clinical course of all three cases was the same. The growths were regarded as cystic because they contained very little solid matter. In two the cystic contents were of mucinoid nature; the contents of the third was pure lymph. Two of the cysts were carcinomatous; the third epitheliomatous. A living specimen, probably epitheliomatous, was also exhibited. The first case was a cellarman, aged fifty-three. The tumour was situated in the left side of the neck; the skin over it was red and brawny. It commenced as a small solid mass, apparently beneath the sterno-mastoid muscle, and was regarded as a "chronic abscess" until an exploratory puncture gave exit to a clear glairy fluid which was pronounced by a chemist to be mucin. The cyst proved to be deeply attached. It discharged continuously, was treated with an injection of iodine, the discharge from it became muco-purulent, bleeding set in from the superior thyroid artery, and death ensued. The necropsy showed an imperfect cyst, whose walls were half an inch thick at most, and whose internal surface was thrown into ridges and bridges like the columnæ carneæ of the ventricles of the heart. It was merely suggested that the mucoid degeneration of the cancer cells in this case might be associated in some way with the atrophy of the thyroid gland



(which was also an observed fact), regard being had to the alleged mucinogenous function of the thyroid. Streckheisen had written about accessory thyroid glands near to the hyoid bone. The diverticulum of epithelium from which thyroid tissue was developed was in direct communication with the foramen cæcum of the tongue; so there was enough epithelial tissue in this neighbourhood for the development of a carcinoma. The second cyst came from a woman aged fifty-two, in which the solid carcinoma formed one-sixth part of the whole mass. This cyst was removed during life; the internal jugular vein was cut, and the brachial plexus exposed; ten days later the woman died from exhaustion. The cyst was of exactly the same structure as in the first case. The third case was epitheliomatous. It occurred in a painter aged forty-three, who was operated on for epithelioma of the right side of the tongue in June, 1885. After ligaturing the lingual artery, the right side of the tongue was removed successfully. In August, 1886, the man, having been engaged in his work till this time, presented himself with a lump in the *left* side of the neck. The skin over it was red and brawny; puncture of the cyst yielded a clear fluid, found chemically to be pure lymph. The further course was characterised by bleeding. After death the cyst wall was found to be not more than a quarter of an inch thick in any part. There were no secondary deposits. Mr. Treves then gave an exhaustive account of the modern and ancient literature of the subject. Cases were quoted.—*Lancet*, Oct. 23.

At a meeting held on December 7th,

Mr. STEPHEN PAGET read a supplementary note on a specimen of *Tumour of the Palate*, exhibited to the Society on November 2nd, 1886. The chief masses of the tumour were epithelial. In a second similar tumour removed by Mr. Walsham there were identical masses of epithelium. In both there were cell-nests, glandular structures, and intervening tracts of embryonic tissue. The existence of cell-nests in tumours which were evidently innocent was a point of great interest. In their history and course these tumours of the palate resembled those occurring in the parotid region, and were probably examples of included embryonic vestiges.

Dr. S. WEST showed an extensive *Epithelioma of the Larynx*, taken from a man aged forty-three, in whom aphonia and dyspnoea of purely laryngeal origin, that necessitated tracheotomy, were the first symptoms. The left vocal cord was found to be fixed, and there was a slough on it. Anti-syphilitic remedies were tried without effect. Mr. Butlin saw the case and advised that extirpation of the larynx should not be practised. The ulceration extended from the base of the epiglottis to the first cartilage of the trachea. The thyroid and arytenoid cartilages were extensively destroyed. There was no very obvious glandular enlargement.—*Lancet*, December 11.

### Royal Medical and Chirurgical Society.

At a meeting held on November 9th, 1886,

A paper was read by Drs. ABERCROMBIE and GAY, *On Three Cases of Acute Tubercular Ulceration of the Fauces*.

The authors relate three cases of acute tuberculosis in children in which ulceration of the fauces occurred within a few days or weeks of death. In one of these cases the ulceration was shown by microscopical examination to be tubercular. In the other two there is no reason to doubt that it was of the same nature.

Pain in the throat and dysphagia are the only premonitory symptoms of this affection, soon followed by the development of whitish punctiform spots, about

the size of a pin's head, on the soft palate, uvula, or tonsils. In the course of a very few days these spots enlarge and coalesce, subsequently breaking down and leaving variously-shaped irregular superficial ulcers. The ulceration may spread until the whole of the fauces are involved. The death of the patient usually occurs before the ulceration is far advanced. Generally the fauces are more or less constantly covered with a viscid secretion, which greatly adds to the difficulty of diagnosis. The usual symptoms of acute tuberculosis will be present, especially the fever and emaciation, but the other signs of the disease are often masked. There is usually, but not always, considerable enlargement of the glands of the neck, and these may suppurate. The differential diagnosis of this affection from diphtheria, tonsillitis, and syphilitic affections of the throat, was briefly discussed.

The authors regard this form of angina as only a part of general tuberculosis, in which respect it differs entirely from the chronic tubercular ulceration of the fauces, which is either primary in the pharynx or spreads there from the larynx.

The disease always proves fatal, though the patients do not usually or necessarily die from the throat affection.

Dr. PERCY KIDD was hardly inclined to separate these cases of pharyngeal tubercle from chronic tubercular laryngitis. The tuberculosis of the larynx, in the great majority of cases, was secondary to that of the lungs, for the passage of infective sputa over the larynx was the commonest origin of tubercle there, and, as a rule, he thought it probable that the pharynx received the infection in the same way, either from the larynx or the lung. There were some cases, it might be objected, in which there were no sputa to carry the infection, or tubercular cavities from which it would come; but, in these, he thought it was always possible, by careful examination, to show that the lung had lost tissue, and that the tissue had come up by the throat. He had seen, in the last 500 necropsies he had made, four cases of tubercle of the soft palate, and some six or seven cases of tubercle of the pharynx; in these there was distinct pulmonary phthisis, and the pharyngeal symptoms had only come on one or two months before death. There was another class of pharyngeal tuberculosis, in which there were large ulcers up to the size of a shilling, with thick edges, on the back of the pharynx; these naturally were only found in chronic cases. He had seen a case lately in which there had been small yellowish patches about the pharynx and palate, whose nature he could not at first determine, which turned out finally to be herpes of the palate, for the patches became vesicular, and disappeared in a week or so. This condition was seldom noticed, and said to be liable to confusion with diphtheria only; but he thought it was certainly more liable to be confused with tubercle.

Dr. ABERCROMBIE said that he imagined the method of inoculation in pharyngeal tubercle, as assumed by Dr. Kidd, implied previous ulceration, which was not present in his cases. He had intentionally omitted any discussion of herpes of the palate in diagnosis, as he thought it was always accompanied by herpes round the mouth.

### Clinical Society.

At the meeting held on November 12th, the following papers were read:—

1. *A Case of Excision of the whole Larynx for Epithelioma.* By Mr. HENRY MORRIS. The disease was confined to the larynx. Tracheotomy had been previously performed. The larynx and cricoid cartilage were excised five months afterwards. Death occurred from exhaustion eight days afterwards. The author thought that total extirpation of the larynx should be done very seldom, and only as a last resort. Two conditions justified the operation: first, where the disease

was intra-laryngeal and could be completely removed ; or where, after tracheotomy, the patient's sufferings were persistent, and suffocative cough and dyspnoea were otherwise unrelievable.

2. *Partial Extirpation of the Larynx for Epithelioma of the Left Ventricle of Morgagni.* By Dr. F. SEMON. The whole of the left vocal cord was embedded in an irregular warty tumour, which was proved to be epithelioma. Dr. Hahn performed extirpation of the left half of the larynx, except the cricoid cartilage. The tumour sprang from the left ventricle.

The patient made a good recovery, and is now—five months after the operation—quite well, free from any recurrence, no longer aphonic, and not wearing a tracheal canula. The author dwelt on the necessity for thorough occlusion of the lower air-passages before the later stages of the operation were proceeded with. He was opposed to the view that extirpation of the larynx was necessary as soon as the diagnosis was clearly made. It should only be practised for intrinsic carcinoma, still limited to the interior of the larynx. Hence early diagnosis was necessary.

3. *A Case of Epithelioma of the Vocal Cord.* By Mr. BUTLIN. The patient had a warty growth on the left vocal cord, which though removed piecemeal during six months, showed recurrence, and the left half of the larynx was removed along with the true and false cords of the right side, which were found to be invaded by the disease. Hahn's tracheotomy tube was left in for two days. The patient was fed through a tube by means of a syringe. The tracheotomy tube was removed on the seventh day. Three weeks after the operation the patient was well. Three months after there was no sign of recurrence and general health was good, and the patient could speak in a gruff whisper. The author drew attention to the rarity of the operation in England, the intrinsic nature of the disease, and the belief that operations could be limited to one half of the larynx. Particular attention was directed to the fact that the soft parts were raised off the cartilage on the right side without removing the laryngeal framework.

A discussion followed the reading of the papers.

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## ASSOCIATION AND CONGRESS MEETINGS.

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### Report of the Laryngological Sub-Section of the 59th Meeting of German Naturalists and Physicians. *Berlin, Sept., 1886.*

(Continued from page 39.)

FIFTH MEETING, 21ST SEPTEMBER.

President, Moritz Schmidt.

HERING.—“*Contribution to the Surgical Treatment of Tubercular Laryngitis.*”

Chronic acid has been very serviceable to the author. He recommends his method of injection of cocaine into the submucous tissues, with the special syringe invented by him. If this is without effect, the walls and base of the ulcer must be scraped with a curette, and then rubbed with lactic acid with the author's brush. If there is much intumescence, they must be cocainised, then many incisions made, and finally rubbed with lactic acid. In one case the necrosed arytenoid cartilage could be removed with forceps. The author demonstrated the larynx of a man

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dead several days before. Three months before the ulcers were scraped, now they are entirely replaced by cicatrices.

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### SIXTH MEETING, 23RD SEPTEMBER.

President, Schnitzler.

ROSENFELD (Stuttgart), "*On Abscess of the Trachea.*"

1. A young lady, after a slight catarrh of the larynx, had hæmoptysis, which could not be pulmonary, from the symptoms, and must have been tracheal. Tracheoscopy showed two ulcers in the mucosa of the trachea, with a central opening, and bleeding vessels. A cure was effected by cauterizing with silver nitrate. 2. A married woman had attacks of dyspnoea. At the level of the second ring of the trachea an abscess was found, which burst the next day. The contents were pus and detritus, like the contents of an atheromatous cyst.

A paper was read by BAYER (Brussels) "*On the Transformation of Mucous Polyps into Malignant Tumours.*"

A mucous polyp, from the concha of a man of fifty, had a cancerous papillome seated on it. In another case, an epithelial carcinoma developed from mucous polyps of twenty years' standing.

A paper was read by LUBLINSKI (Berlin) "*On Laryngitis Sicca.*"

There is a form of laryngitis sicca which sometimes develops from a pharyngitis sicca, continued into the larynx. It is not an acute process, being in some cases preceded by a granular laryngitis. There is produced a very atrophic mucous membrane, covered with viscous crusts. The treatment must first cure the affection of the pharynx and nose. For this potash hydroxide is the best; for the larynx a 2 % solution of zinc chloride.

STOERK. This affection is incurable. The best treatment is prophylactic; the removing of the secretion. Dryness in inflammation is another form, always curable.

MICHAEL (Hamburg). If dryness of the mucosa is the characteristic symptom of laryngitis sicca, there is an acute form. A girl of fifteen had such acute dyspnoea that tracheotomy seemed unavoidable. The larynx was covered with yellow crusts. As these crusts were removed with a brush, the dyspnoea vanished, and the affection was cured in some days. He has also seen other cases. The best treatment for pharyngitis and rhinitis sicca is the sniffing through the nose of warm milk, and for laryngitis sicca the spraying of warm milk.

TORNWALDT recommends the designation only of those cases where there is an atrophy of the mucous membrane as pharyngitis and laryngitis sicca.

M. SCHMIDT has seen the affection mostly in women, has also seen an acute case in a boy of ten. Removal of the crusts is of great importance.

BAYER recommends local treatment with zinc chloride, arsenic internally, and apomorphine.

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### FINAL MEETING, 23RD SEPTEMBER.

Presidents, Schnitzler and Schmidt.

SCHWABACH (Berlin), "*On the Bursa Pharyngea.*"

This was a demonstration that Tornwaldt's so-called pharyngeal bursa is only a cleft, not a separate structure, but only a part of the pharyngeal tonsil.

TORNWALDT (Dantzig) does not attach any importance to the name itself.

A paper read by TORNWALDT (Dantzig) "*On Chronic Retronasal Catarrh.*"

Very different pathological conditions may produce these symptoms. Hypersecretion may exist of (a) the bursa pharyngea, (b) of the adenoid tissue, (c) of acinous glands, (d) of follicles, (e) of portions of the mucosa, (f) of the whole mucosa, of

the nasal or other cavities. Diagnostic of the various affections are (1) the place whence the secretion issues, (2) the persistence of secretion from these spots on repeated examination. An accurate diagnosis leads to more efficient local treatment.

BÖCKER (Berlin) illustrated the difference between organic and hysterical paralyses of the dilatores glottis phonatoria.

MORELLI (Pesth) had seen many cases of dry catarrhs in young females. The condition is most painful if the trachea is affected. Tracheotomy is never indicated. He treats by brushing with carbolic glycerine.

GAKSTEIN (Breslau) remarked that there is a laryngitis sicca, independently of catarrhs of the pharynx, a well-characterized affection, with peculiar symptoms.

HERING gave a demonstration of histological specimens of phthisis laryngis.

A paper was read by SCHADEWALT (Berlin) "*On the Localization of Sensation in the Organs of the Neck and Throat.*"

The faculty of localizing sensations is imperfect. Irritations in nares, nasopharynx, &c., are often localized in the regio laryngo-trachealis. This is analogous to the habit of localizing sensations produced in the uro-genital apparatus, in the forsa navicularis.

HEYMANN (Berlin) *demonstrated a case of tracheocele.*

The patient was a child, four years old, in which the mother had for some weeks, during speaking and coughing, noticed an intumescence of the neck. A round tympanitic tumour comes into view at every forced expiration. The communication between the trachea and the hernia cannot be very large, since it is slow in filling. There is no pain. The child is hoarse, not from the tumour, but from chronic catarrh.

KOEHLER (Posen) *demonstrated two rhinoliths*, one from a girl of thirteen, who had had fetid secretion for seven years; the other from a woman of forty-three.

MORELLI (Pesth) *demonstrated a rhinolith*, formed from the kernel of a cherry.

SCHLESINGER *demonstrated a rhinolith*, formed from a piece of iron.

SCHMIDT *demonstrated a rhinolith*, formed round a piece of buckthorn.

A paper was read by SCHNITZLER "*On the Combination of Syphilis and Tuberculosis of the Larynx.*"

This is very frequent. Syphilitic ulcers may become transformed into tuberculous, these ulcers being a good ground for the development of the tubercle bacillus. The differential diagnosis is not at all easy. Attention must not only be directed to the larynx, but to the whole constitution.

FRÄNKEL.—The detection of the bacillus will settle the diagnosis.

SCHLESINGER (Dresden) *gave a demonstration of the instruments used by him in rhinoscopic operations*, with remarks.

LÖWE (Berlin) *demonstrated that* in rabbits:—1. In the cristæ septarum cellularum ethmoidalium, there is true olfactory epithelium, and situated in the walls, between the cristæ, is true respiratory epithelium. The cristæ are covered also with the true olfactory glands. 2. The organ of Jacobson is a hollow tube, ending blindly on the septum, containing many olfactory cells. It is part, therefore, of the olfactory organ. 3. All the glands of the antrum of Highmore have a common duct, emptying into the nasal cavity.

COËN (Vienna) *described a New Method of Treating Stammering.*

The author made the patient whisper for some days, then speak in gradually increasing tones, ascending the musical scale till the pitch was reached natural to the individual's own voice.

MICHAEL (Hamburg).



## REVIEW.

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**Tonsillitis in Adolescents.**—By C. HAIG BROWN, M.D. *London: Ballière, Tindall, & Cox.*

THE author's observations are based upon the experience furnished by 500 boys, between the ages of twelve and nineteen years, and are embodied in the work now before us.

In writing of the causation of the complaint the author says, (footnote, p. 10): "A further relation between the tonsils and generative organs is suggested by the occasional occurrence of atrophy of one testicle after removal of the corresponding tonsil." We should like to inquire of the author what proof he can adduce in support of this statement, and, more particularly, can he refer us to any well-authenticated case where this has occurred? The view here expressed was considered by us as quite obsolete; it is certainly contrary to the opinion of those who have had most experience of tonsillotomy, and its general adoption would tend to discredit one of the most beneficial and legitimate operations in surgery.

The author attempts to substantiate the theory that adolescence, the tonsils, and the testicles are intimately related by the fact that, of 127 of his cases of tonsillitis, 105 were boys between fourteen and seventeen years, a period when the generative organs commence to be unusually active. As the limits of age of the *whole* of his patients were twelve and nineteen years, it is highly probable that the great majority of them range from fourteen to seventeen years, and in any endemic or epidemic disease the most of the sufferers would belong to these same ages. We cannot regard the fact as affording any proof of the connection between the tonsils and the testicles.

The author finds that the presence of moisture is the most important atmospheric condition in determining attacks of tonsillitis. He believes that contagion is an agent in the causation of follicular tonsillitis, and that this contagion is most virulent and most certain at the commencement of the disease.

In the chapter dealing with the complications, the author gives a careful description of the cardiac murmurs which may develop during tonsillitis, and of their significance. Of 345 cases a cardiac murmur was developed in 33 instances (9 per cent.), the most common being a systolic apex murmur. The majority of these disappeared within three weeks.

In the important chapter devoted to treatment the author not only

omits to mention the value of local depletion in the early stages of tonsillitis, but even in cases in which suppuration has taken place he says (p. 56): "A natural exit for the pus occurs usually in about six days, and it is advisable to avoid using a knife to the back of the mouth, unless the need to do so is urgent." Surely the author can have had little, if any, and certainly no personal experience, of the great relief afforded by the *early* use of the knife in threatened or actual abscess of the tonsil or its vicinity, or he would not recommend a prolongation of the torture until such time as the pus had made its own exit.

The book contains many careful and valuable observations, and were it not for certain views of the author regarding causation and treatment, to which we have felt it our duty to refer in some detail, would call for little criticism.

G. HUNTER MACKENZIE.

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## NOTES.

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**A Correction.**—Dr. Moure, writing to us with reference to the review of his "Manuel Pratique des Maladies des Fosses Nasales et de la Cavité Naso-Pharyngienne," wishes it to be understood that he does not definitely commit himself to the view that atrophied turbinated bodies are ever regenerated. The passage referring to this point in his work runs as follows:—"The nasal cavities, very large and spacious at the commencement" (of treatment for atrophic rhinitis), "have seemed to regain, little by little, their normal volume, by a sort of regeneration of the atrophied parts. I repeat, I advance the fact only with the greatest reserve, having the intention of returning to this subject, so full of interest, when further observation will have allowed me to confirm this fact, or, on the contrary, to recognize the error of an assertion, still perhaps a little hazardous." M. Moure also wishes to explain the reason why he has not gone more fully into the bibliography of the subject in his book. This is, that being engaged in translating the second volume of Dr. Morell Mackenzie's work on Diseases of the Throat and Nose into French, in which this matter is most fully dealt with, he considered it superfluous to introduce bibliography into his smaller manual. G. MACD.

**Our eminent confrère,** Dr. Solis Cohen, has been elected President of the Philadelphia County Medical Society, and Dr. Solomon Solis Cohen has been appointed the Reporting Secretary of the same.

**The name of** Dr. David Collingwood, of Sydney, is this month added to the list of our collaborateurs.

**The Spanish Society of Hygiene** has awarded its first prize in the recent competition to Dr. Manuel de Tolosa Latour, of Madrid, for his Essay, "Popular Instructions to avoid the Propagation of Diphtheria" (*Anales de Otologia y Laryngologia*, No. 10, 1886).

**Laryngeal Vertigo.**—It is plain that the profession, as a whole, has no great objection to the use of etymologically unfit words. "Laryngeal vertigo" is one more specimen. The vertigo is not specially related to the larynx in what

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Charcot called "laryngeal vertigo." The vertigo in this case is the result of coughing. Giddiness and dizziness, with mental confusion and even loss of consciousness, as the effect of paroxysms of coughing, are symptoms of every-day occurrence; and yet Charcot and others are inclined to perceive in this phenomenon something of an extraordinary nature and worthy of a separate description and name. We cannot subscribe to the opinion that there is any necessity for a new name to designate such old symptoms. In order to understand as far as possible the principles concerned in this laryngeal vertigo, "laryngeal epilepsy," or "complete spasm of the glottis," as it has been called by different authors, we should state the matter thus: Every individual is liable to be attacked with loss of consciousness in the event of a sufficiently powerful exciting cause, but the liability to this "epilepsy," if we may so call it, using the term in the catholic sense of Hughlings-Jackson, varies immensely in different individuals, and in the same individual at different times. A slight fit of coughing in a subject of great nervous susceptibility might lead to a vertigo, whereas a prolonged attack of coughing of great severity might fail to affect the consciousness of an individual possessed of healthier nerves. The matter is largely one of degree of coughing and degree of nervous susceptibility. It does not necessarily follow that an epileptic person is the more prone to become unconscious with paroxysms of coughing; it is possible that some epileptics may have their nervous centres less liable to "explode" in the face of passive congestion resulting from expiratory efforts.—From *The Lancet*, No. 17, vol. ii., October 23, 1886.

The paper read at the British Medical Association in August entitled "The Function of the Recurrent Laryngeal Nerve," and quoted in our last number, was by Dr. Frank Donaldson, *Junior*.

**Books, Pamphlets, &c., received.**—*Edinburgh Medical Journal*. *Archiv. f. Kinderheilkunde*. *Revista de Laringologia, Otologia, y Rinologia*. *Anales de Otologia y Laringologia*. *Annales des Maladies de l'Oreille, du Larynx, etc.* *Gazette des Hôpitaux*. *L'Asthme et les Affections Nasales: Laryngitis sicca S. Atrophica; Ueber die Jodol-Behandlung der Larynx-Tuberculose: Lublinski*. *Endo-Tracheitis and Endo-Bronchitis: R. W. Parker*. *Influence du Laryngoscope sur le Diagnostic des Affections extra-Laryngiennes: Koch*. *Ueber Angioneurotisches Larynx-Ödem: Strübing*. *Ein Knochenstück in der Kehlkopfshöhle eines 22 Monate alten Kindes, Laryngoscopisch Nachgewiesen und Entfernt: Jurasz*. *Ueber im Pharynx Localisirte Hydrargyrose: Sommerbrodt*. *Intubation of the Larynx: Jennings*. *Ueber Keuchhusten Behandlung: Michael*. *Ueber Esophagitis Acuta; Ueber die lokale Behandlung des Empyems der Highmorshöhle: Stoerk*. *Lepros, Lupus, and Cancer of the Throat (Ramon de la Sota)*, translated by H. A. Allbutt.

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TUBERCULAR DISEASE OF THE  
UPPER AIR-PASSAGES.

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TUBERCULAR disease of the larynx ranks third in frequency amongst the organs or regions so affected, the order being, according to Heinze<sup>1</sup>: (1) Lungs; (2) Intestines; (3) Larynx. The frequency of its occurrence during the course of pulmonary phthisis was found by Morell Mackenzie<sup>2</sup> to be 33 per cent. ; by Heinze,<sup>3</sup> 30·6 per cent. ; and more recently by Bosworth,<sup>4</sup> about 30 per cent. Tubercular affections of the gullet, the pharynx, and the buccal and nasal cavities are of more rare occurrence, and it is only within comparatively recent years that much attention has been bestowed upon them.

One of the most keenly debated points within the range of laryngological science has been the relation of pulmonary to laryngeal tuberculosis. Thus we are told no later than 1880<sup>5</sup> that "no case of primary laryngeal phthisis has ever been recorded in which post-mortem examination showed that there was true tubercular ulceration of the larynx as a primary affection, whilst the lungs were intact." This statement can no longer be maintained, for Demme<sup>6</sup> has reported the case of a boy, aged four and a half years, in which the necropsy showed the presence of laryngeal ulceration *with tubercle bacilli*, the thoracic and abdominal organs being at the same time free from tubercular disease. Cases of primary laryngeal tubercular disease (no necropsies) have also been recorded by Morel-Lavallée<sup>7</sup> in a child twelve years old ; by Cahn,<sup>8</sup> who relates a case of primary disease of the epiglottis, and recommended its extirpation before the

<sup>1</sup> *Die Kehlkopfschwindsucht* (Quoted by Morell Mackenzie, *Diseases of the Throat and Nose*, vol. i. p. 365).

<sup>2</sup> *Diseases of the Throat and Nose*, vol. i. p. 366.

<sup>3</sup> *Op. cit.*

<sup>4</sup> *New York Medical Journal*, October 18, 1884.

<sup>5</sup> Heinze (Quoted by Morell Mackenzie, *Op. cit.*, p. 371).

<sup>6</sup> *Bericht über die Thätigkeit des Jennerschen Kinderspitals*. Bern, 1883.

<sup>7</sup> *La France Médicale*, November 20, 1884.

<sup>8</sup> *Annales des Mal. de l'Oreille*, July, 1883.

lungs became affected ; by Ziegelmayr,<sup>1</sup> who has placed on record a case of tubercular ulcer of the larynx which healed, the lungs remaining unaffected throughout ; by Déjerine,<sup>2</sup> whose case was one of tubercular (bacillary) disease of the larynx, with healthy lungs ; and by Neidert,<sup>3</sup> whose case was somewhat similar to that of Déjerine. In the records of these and similar cases, and especially in the valuable and instructive case of Demme, we have evidence that primary tubercular disease may not only affect the larynx, but may even cause death without the lungs becoming affected.

The physical characters of tubercular disease of the larynx, as revealed by the laryngoscope, appear to be of a threefold character—infiltration, ulceration, and growths or tumours. The two former have been so long recognized, and so frequently and carefully described by various writers, as to demand little attention at our hands. Infiltration of the epiglottis has been described by Moeser<sup>4</sup> as a primary sign of laryngeal phthisis, with no, or little lung affection. Catarrhal or erosive ulcers appear to have no relation to tubercular bacillary ulcers, even with the co-existence of pulmonary apical catarrh (Hering<sup>5</sup>), and on the other hand there is a great disposition to regard genuine or deep ulceration of the larynx as incompatible with simple affections, and as being always the result of a dyscrasia (Gottstein<sup>6</sup>), of which the tubercular is the most common (Hunter Mackenzie<sup>7</sup>). That vegetations, growths, or tumours may be amongst the appearances presented by tubercular disease of the larynx is not so generally recognized, and, indeed, it is only within recent years that this fact has been noted. To Ariza,<sup>8</sup> and John Mackenzie,<sup>9</sup> of Baltimore, the credit seems due of having been the first to direct attention to this important fact. Their communications were followed by several on the same subject by Schnitzler,<sup>10</sup> Percy Kidd,<sup>11</sup> Gouguenheim,<sup>12</sup> and others. According

<sup>1</sup> *Bad-bericht über der Saison 1885 im Schwefelbade Langenbrücken*, 1886.

<sup>2</sup> *Gazette des Hôpitaux*, February 14, 1885.

<sup>3</sup> *Monatsschrift für Ohren, &c.*, No. 12, 1885.

<sup>4</sup> *Mittheilungen aus der med. Klinik zu Würzburg*. Wiesbaden, 1885.

<sup>5</sup> *Verlag der Gazeta lekarska*, 1884.

<sup>6</sup> *Verhandlungen der laryngologischen Section der 58 Versammlung deutscher Naturforscher, &c.*, September, 1885.

<sup>7</sup> *Edinburgh Medical Journal*, January, 1887.

<sup>8</sup> *Anfiteatro Anatómico Español*, 1877, p. 149, &c.

<sup>9</sup> *Archives of Medicine*. New York, 1882.

<sup>10</sup> *Wiener med. Presse*, April, 1883.

<sup>11</sup> *British Medical Journal*, April 26, 1884 ; and *St. Bartholomew's Hospital Report*, vol. xxi. 1885.

<sup>12</sup> *Annales des Malad. de l'Oreille, &c.*, No. 3, 1884.



to these observers such tubercular tumours may be situated on the epiglottis, in the interarytenoid region, and on both extremities of the vocal cords; their most usual situations, however, are the retro-laryngeal wall and interarytenoid fold. They may be single or multiple, are usually round with a smooth surface, of greyish or whitish colour, and vary in size from a pea to a small cherry or hazel-nut. They may remain for a long period before ulcerating. Occasionally they have a papillomatous appearance, and Major<sup>1</sup> attributes importance to this post-laryngeal papillomatous appearance in the diagnosis of laryngeal phthisis. Lermoyez<sup>2</sup> describes a case of enormous tubercular vegetations in the larynx which necessitated tracheotomy, and Soyer<sup>3</sup> has narrated similar cases. These tumours ought not to be confounded with the swellings of abscesses from perichondritis, which are sometimes met with in the larynges of tubercular individuals, nor with the large granulations which occasionally accompany tubercular ulceration in this region. Tubercular growths may be infra-glottic and even intra-tracheal in situation. Thus Schmiegelow<sup>4</sup> reports the case of a man, aged forty-four years, who had, along with tubercular infiltration of the larynx, a tubercular mass about the size of a pea situated on the anterior tracheal wall, about 1 centimetre under the rima glottidis.

The appearances presented by tubercular disease of the gullet, the pharynx, and the nose are somewhat similar to those met with within the larynx, though the disease probably occurs more rarely in the whole of these combined than in the larynx. Cases of tubercular disease of the gullet have been recorded by Mazzotti,<sup>5</sup> in a boy ten years of age who suffered from acute miliary tuberculosis, and by Selenckow,<sup>6</sup> who reports a case of partial tubercular destruction of the œsophagus necessitating gastrostomy. The gullet seems liable to tubercular infection by direct extension of the disease from infected areas, or through the medium of glands. Thus, in addition to Selenckow's case, Weichselbaum<sup>7</sup> reports a case due to perforation both of the trachea and gullet by cheesy glands, and subsequent deposition of tubercle in the form of nodules and ulcers,

<sup>1</sup> *Transactions of the Fifth Annual Meeting of the American Laryngological Association*, 1883.

<sup>2</sup> *Annales des Malad. de l'Oreille, &c.*, No. 3, 1884.

<sup>3</sup> *Thèse*, August 2, 1884. Paris.

<sup>4</sup> *Förste Beretning fra Commune-hospitalets clinic for ore, &c. Hospitals Tidende*. March, 1885.

<sup>5</sup> *Rivista Clinica*, No. 1, 1885.

<sup>6</sup> *Petersburg med. Wochen*, No. 49, 1884.

<sup>7</sup> *Wiener med. Wochen*, No. 6, 1884.

containing bacilli in both canals; Beck,<sup>1</sup> a case due to perforation of the gullet by a cheesy gland, and one by extension of the disease from the larynx and pharynx; and Rey,<sup>2</sup> a case of laryngeal phthisis with perforation of the retro-laryngeal wall, due, he thinks, to passage of the sound over a previously tubercular spot in the gullet. Mazzotti calls attention to the fact that in three cases observed by him no cesophageal symptoms were present, and he thinks that the disease may possibly not be so rare as is commonly supposed.

In the pharynx and mouth, tubercular disease, when present, is usually a complication of pre-existent pulmonary or laryngeal tuberculosis, or of both combined. Some cases of apparently primary disease in these regions have lately been recorded. Abraham<sup>3</sup> has reported a case of primary tubercular disease of the tonsils,—the other parts of the fauces, and the pharynx, larynx, and lungs being free from the disease, and no constitutional symptoms being present. He thinks tubercular disease of the tonsils would be more often seen if looked for. Kendal Franks<sup>4</sup> relates a somewhat similar case, but in this instance the pharynx and root of the tongue also became tubercular. When the proneness of the tonsils to poisoning by atmospheric influences is considered, it is rather surprising than otherwise, that more examples of primary tonsillar tubercular disease have not been recorded. An example of primary disease affecting the soft palate in a patient forty-three years of age, has been recorded by Bryson Delavan.<sup>5</sup> Secondary tubercular disease of the pharynx is not uncommon. According to Volkmann<sup>6</sup> it is usually met with about the time of puberty, or soon afterwards. It rarely assumes the miliary form (Réthi<sup>6</sup>), the affected mucous membrane being covered with rose-coloured spots with ulcerated centres, but usually presents the forms of simple infiltration or of ulceration. The ulceration is generally superficial in character, but cases have been recorded by De Conciliis<sup>7</sup> and Whitehall,<sup>8</sup> in which the ulceration was so deep and so extensive as to destroy large portions or even the whole of the soft palate. Ariza<sup>9</sup> has described

<sup>1</sup> *Prager med. Wochenschrift*, No. 35, 1884.

<sup>2</sup> *Progrès Méd.*, No. 18, May, 1885.

<sup>3</sup> *Dublin Journal of Medical Science*, October, 1885.

<sup>4</sup> *Ibid.*

<sup>5</sup> *Report of the Eighth Annual Meeting of the American Laryngological Association*, 1886.

<sup>6</sup> *Wiener med. Presse*, Nos. 37, 38, and 40, 1885.

<sup>7</sup> *Archivii di Laringologia*, fasc. iv., April, 1884.

<sup>8</sup> *Medical Press of Western New York*, May, 1886.

<sup>9</sup> *Revista de Medicina y Cirurgia Práticas*, December, 1886.

a case of acute tubercular (bacillary) pharyngitis, with a granular and ulcerated appearance, which was amenable to treatment. Abercrombie and Gay<sup>1</sup> have lately reported three cases of acute tubercular ulceration of the fauces in children. The local manifestations were whitish punctiform spots, about the size of pins' heads, on the faucial mucous membrane; these subsequently coalesced and formed ulcers. In the discussion which followed, Percy Kidd remarked that, out of 500 necropsies, he had seen four cases of tubercle of the soft palate, and six or seven of tubercle of the pharynx; in all the cases there had been previous lung disease. Retro-pharyngeal abscesses in children are usually due to tubercular disease of the spine.

The tongue appears to be a somewhat favourite seat of tubercular disease. According to Volkmann<sup>2</sup> the manifestations of the disease in this organ may be either in the form of ulcers, or of distinct tumours which gradually soften in the centre, the former having certain resemblances to malignant, and the latter to late syphilitic (gummous) disease. These tumours may remain a long time, and attain a large size. Gade<sup>3</sup> narrates a case of tubercular (bacillary) tumour of the left side of the tongue, of the size of a walnut. Occasionally, fissures may be present, as in a case recorded by Stewart,<sup>4</sup> where the lesion present was superficial ulceration with hard and thickened surroundings, and a fissure extending into the substance of the organ. The disease may, as in the case of other regions and organs, be primary or secondary. Of 24 cases reported by Bryson Delavan,<sup>5</sup> nine were primary; with one exception all were in men. He found the most frequent seats to be first the front, and second the sides; and in one case only did the lesion affect the root of the tongue. Bruce and James<sup>6</sup> have reported a case of secondary tuberculous ulcer of the tip of the tongue.

Amongst the other seats of tuberculous disease in this region may be mentioned the lips, two cases of which (ulcers) have been recorded by Volkmann<sup>7</sup> and two by Hansemann<sup>8</sup>; the buccal mucous membrane (Kraske<sup>9</sup>); the cheek, an example of this in a

<sup>1</sup> *Royal Medical and Chirurgical Society*, November 9, 1886.

<sup>2</sup> *Beiblatt zum Centralblatt für Chirurgie*, No. 24, 1885.

<sup>3</sup> *Nordisk Magazin for Lægevidenskab* 14, B. 2, 11. 1884.

<sup>4</sup> *Philadelphia Medical News*, May 29, 1886.

<sup>5</sup> *Report of the Eighth Annual Meeting of the American Laryngological Association*, 1886.

<sup>6</sup> *Edinburgh Medical Journal*, 1886.

<sup>7</sup> *Beiblatt zum Centralblatt für Chirurgie*, No. 24, 1885.

<sup>8</sup> *Virchow's Archiv.*, Bd. 103, S. 264.

<sup>9</sup> *Beiblatt zum Centralblatt für Chirurgie*, No. 24, 1885.

child six years of age having been reported by Bryson Delavan,<sup>1</sup> and the gums (Mader<sup>2</sup>), on which an ulcer about the size of a bean was situated near the first molar tooth. Clifford Beale<sup>3</sup> has lately reported a case of single tuberculous ulcer of the mouth, near the last molar tooth.

It is interesting to observe that wounds or abrasions of the mucous membrane of the tongue or lips, preferably in patients already tubercular, may act as starting points for local manifestations of the tubercular process. Thus Ehrlich<sup>4</sup> records a case of a phthisical individual who had wounded his lip, and in whom a tubercular (bacillary) ulcer formed at the seat of injury. Graser<sup>5</sup> reports an example of a tumour about the size of a walnut with a deep ulcer in its centre, which he supposed tubercular (primary), though no bacilli were found, and which he attributed to burning of the tongue with a cigar. If his views as to the nature and cause of this tumour be correct, which is very problematical, the case is certainly unique.

In the nasal cavities tubercular disease is now found to be not so rare as was formerly supposed. For example, only a few years ago, Fraenkel,<sup>6</sup> in an article on the subject, affirms that there is only one reference to it in medical literature. Recently, however, cases of tubercular nasal disease have been recorded by Sokolowski,<sup>7</sup> who mentions a case of painful tubercular (bacillary) ulceration of the nasal mucous membrane, with a tumour about the size of a pea at its upper border, occurring in the course of laryngeal and pulmonary phthisis; by Volkmann,<sup>8</sup> who writes of what he styles tubercular ozæna; and by König and Riedel,<sup>9</sup> who report an extraordinary form of nasal tuberculosis in the shape of a fibroma of the septum. In Clutton's<sup>10</sup> case of tubercular ulcer of the palate, the disease subsequently extended to the interior of the nose, and one auditory canal. It must still be admitted, however, that tubercular nasal disease, whilst not so rare as was formerly supposed, is not so prevalent as similar disease of the pharyngo-oral cavity.

<sup>1</sup> *Report of the Eighth Annual Meeting of the American Laryngological Association*, 1886.

<sup>2</sup> *Bericht der k. k. Krankenhospital Rudolph Stiftung in Wien*, 1884.

<sup>3</sup> *British Medical Journal*, March 20, 1886.

<sup>4</sup> *Berliner klinische Wochenschrift*, No. 41, 1885.

<sup>5</sup> *Sitzungsber. der phys.-med. Societät zu Erlangen*, 1884.

<sup>6</sup> *Ziemssen's Cyclopadia* (English Translation), vol. iii.

<sup>7</sup> *Gazeta Lekarska*, No. 15, 1885.

<sup>8</sup> *Beiblatt zum Centralblatt für Chirurgie*, No. 24, 1885.

<sup>9</sup> *Ibid.*

<sup>10</sup> *Transactions of the Clinical Society of London*, vol. xix. p. 197.

The usual local accompaniments of tubercular disease in these regions are a certain amount of chronic inflammation and œdema. In tubercle of the larynx, indeed, œdema of the larynx may be present to a marked degree (Morel-Lavallée).<sup>1</sup> Simple chronic laryngitis may not only accompany, but may precede or initiate tubercular changes (Hunter Mackenzie).<sup>2</sup> Syphilis may be a concomitant of tubercle; of this Irsai<sup>3</sup> reports four cases, and Cardone<sup>4</sup> one—a case of gummous tumour of the pharynx concurrently with tubercular (bacillary) disease of the larynx. Fränkel<sup>5</sup> records a case in which tubercular disease supervened on a case of syphilitic ulcer of the lip. Schnitzler<sup>6</sup> believes that syphilitic ulcers form good soil for the implantation and development of the bacilli of tubercle: he thinks that this combination is very common in the larynx. Hanse-mann<sup>7</sup> has placed on record a case of tubercular (bacillary) disease of the mucous membrane of the mouth, coming on after cancer of the lip. The writer believes that tubercle and lupus of these regions may co-exist.

Consideration of these possible combinations will assist in opening the eyes of the observer to the diagnostic pitfalls which lie in his path. The writer does not believe that it is possible, by a mere description of the naked-eye appearances of the local lesions of tuberculosis, to lay down rules which will enable the clinician to arrive at a correct diagnosis. Unquestionably the most important advance within recent years in regard to the diagnosis of these, as of tubercular lesions elsewhere, is of a microscopical character, and consists in the detection of tubercle bacilli, not necessarily in the sputum, but in the secretions and lesions of the various structures. In the case of the larynx, as first pointed out by Fränkel,<sup>8</sup> some of the laryngeal secretion, preferably from any ulcerated spots, ought to be removed by mechanical means, and submitted to the test for tubercle bacilli. In the cases of tubercular ulcers of the mouth and pharynx, bacilli are not usually found in their secretion, probably owing to the passage of food and drink, and the movements connected with mastication preventing their aggregation. The writer has found that it is necessary to carefully cleanse and subsequently to scrape such

<sup>1</sup> *La France Méd.*, November 20, 1884.

<sup>2</sup> *Lancet*, February 14, 1885.

<sup>3</sup> *Wiener med. Presse*, Nos. 42 and 43, 1884.

<sup>4</sup> *Archivii di Laringologia*, fasc. 3 and 4, 1886.

<sup>5</sup> *Berliner klinische Wochen.*, Nos. 13 and 14, 1884.

<sup>6</sup> *Journal of Laryngology and Rhinology*, vol. i. p. 84.

<sup>7</sup> *Virchow's Archiv.*, Bd. 103, S. 264.

<sup>8</sup> *Berliner klin. Wochen.*, No. 3, 1883.



ulcers, in order to find bacilli, and even then they may be but few in number. Hansemann<sup>1</sup> has recorded a case of tuberculous ulcer of the tongue with no bacilli in the sputum or in the secretion of the ulcer, but after death bacilli were found in the excised ulcer.

In considering the recent literature of tubercular disease, in its laryngeal and allied aspects, one cannot help being struck with the extreme youth of some of its subjects. Thus Laurent<sup>2</sup> reports the case of tubercular disease of the tongue in a child eleven years of age; Morel-Lavallée,<sup>3</sup> a case of primary tubercular disease of the larynx in a child of twelve; Van Santevoord,<sup>4</sup> a fatal case of tubercular disease of the larynx and lungs in a child aged thirty-one months, (this being the youngest case of tubercular disease of the larynx on record); Demme,<sup>5</sup> the patient already referred to, aged four-and-a-half years; Voltolini,<sup>6</sup> a case of tubercular (bacillary) disease of the larynx in a child five years of age; and Elliot,<sup>7</sup> a case of laryngeal phthisis in a child of six, in which the dyspnoea became so great as to necessitate tracheotomy. A case of tubercular disease of the gullet has been recorded by Mazzoti,<sup>8</sup> the subject being a boy of ten. Bryson Delavan<sup>9</sup> has reported a case of tubercular disease of the cheek in a child six years of age. Clutton<sup>10</sup> records and illustrates a unique case of tubercular ulceration of the hard and soft palate and larynx in a girl aged fifteen years, in which partial healing took place.

From this retrospect, which is by no means exhaustive, but merely to some extent illustrative of the subject, it is seen that tubercular disease may affect any region or part of the upper air-passages, frequently in such diverse and obscure forms as to render its recognition a matter of difficulty, even by the experienced observer. In all cases the prognosis is highly unfavourable, though in some few instances healing of the local lesions is reported to have taken place.

G. H. M.

<sup>1</sup> *Virchow's Archiv.*, Bd. 103, S. 264.

<sup>2</sup> *Société des Sciences Méd. de Lyon*, January, 1884.

<sup>3</sup> *La France Méd.*, November 20, 1884.

<sup>4</sup> *New York Medical Record*, March 14, 1885.

<sup>5</sup> *Bericht über die Thätigkeit des Jennerschen Kinderspitals.* Bern, 1882.

<sup>6</sup> *Deutsche med. Wochen.*, No. 24, 1884.

<sup>7</sup> *Bristol Medico-Chirurgical Journal*, December, 1884.

<sup>8</sup> *Rivista Clinica*, No. 1, 1885.

<sup>9</sup> *Report of the Eighth Annual Meeting of the American Laryngological Association*, 1886.

<sup>10</sup> *Transactions of the Clinical Society of London*, vol. xix., p. 197.

## THERAPEUTICS AND INSTRUMENTS.

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**KILHAM.**—Case of Cocaine Poisoning. *Lancet*, January 1, 1887.

A MAN, after accidentally taking  $\frac{4}{5}$  gr. of cocaine at 12.10, was seized at 12.30 with cramps in the stomach, nausea, throbbing and bursting sensation of the head, failure of eyesight, loss of the use of his legs, incoherence of speech, confusion of ideas, and drowsiness, but could always answer questions if roused. No delirium; appeared as if drunk, and got quite helpless. Forty minutes after taking the drug, most profuse sweating, lasting some time, after which severe prostration, shivering, and sense of impending death. Stomach cramps, retching, and mucous vomiting followed. Seventy-five minutes after, face cyanosed, pulse intermittent, and cardiac suffocation. Half an hour after this, cramps in legs and feet, with numbness and tingling of the hands. The pupils also became dilated. Not until six hours after taking the drug did the patient begin to amend, but great weakness and head swimming remained all night. The loss of power (which appeared thirty-six hours after ingestion of the cocaine) in the legs, lasted three days, and numbness and tingling in the hands, for some time longer. The patient could not write a letter until the sixth day, being unable to feel a pen between the fingers. Severe sweating, intense prostration, and intermittence of the pulse were the most prominent symptoms.

**CHAPIN, AMORY** (New York).—The Use of Cocaine in Coryza. *The Medical Record*, January 15, 1887.

THE author has found the combination of "Dobell's Solution," with 4 per cent. solution of cocaine, warmed and used with a hand bulb atomizer, very successful in aborting "cold in the head."

**RABOW.**—Snuffs for Nasal Catarrh. *Deuts. Med. Woch.*, 1886, No. 5.

1. Menthol pulv. 3 grains.  
Coffæ tostæ,  
Sacch. alb.      āā 50 grains. To be used like common snuff.
2. Cocaine hydrochlor.  $1\frac{1}{2}$  grains.  
Coffæ tostæ,  
Sacch. alb.      āā 50 grains. To be used as snuff.

**STOCQUART** (Brussels).—On the Hypodermic Injection of Sub-acetate of Ammonia for the Cure of Aphonia and Hoarseness, recent and chronic. (*Des Injections sous-cutanées d'Acetate d'Ammoniaque dans le Traitement de l'Aphonie et des Enrouements recents et chroniques.*) *Archiv Mens de Med. et Chir. Pratiques*, October, 1886.

ON account of the absence of laryngoscopic examination, the author's diagnosis of "chronic laryngitis" cannot be said to have much value. The treatment, however, deserves a trial on account of the well-known repute of the salts of ammonia, more especially in Belgium and France, for the cure of throat complaints. The author comes to the following conclusions:—

1. Watery solutions of acetate of ammonia in the strength of  $\frac{1}{10}$ ,  $\frac{1}{5}$ , or  $\frac{1}{3}$  per cent., injected into the neck to the amount of one gramme, are without danger and are well supported by the patient.
2. The remedy is good for any case of aphonia or hoarseness, whatever the nature of the complaint. CAPART.

**RUAULT.**—On the Employment of Benzoate of Soda in some Catarrhal or Congestive Affections of the Upper Air Passages (*Note sur l'Emploi du Benzoate de Soude dans quelques Affections Catarrhales ou Congestives des premières voies.*) *France Medicale*, January, 1887.

THIS drug having antithermic properties, the author conceived the idea of employing it in catarrh of the upper air tract, and has obtained good results. Four or six grammes at least must be given for a dose. The author has given it to a number of patients suffering from common colds, ending in tracheo-bronchitis. In many cases it has cut short the development of the complaint, and effected a cure in seven or eight days. In primary acute laryngitis the effects have been very marked: at the end of three days the mucous membrane was much less red, the cough diminished, and the voice better. Equally satisfactory results were obtained in a case of superficial erythematous angina. The chronic forms of the various catarrhal affections are also amenable to this treatment, especially simple chronic coryza with exaggerated secretion. Granular angina is also modified by benzoate of soda, which acts not only upon the granules themselves, but on the congestive element which accompanies them. Benzoate of soda would appear to have upon the mucous membranes of the upper air tract the same effect that balsams, such as terpene,

have upon the bronchitic mucous membrane, and turpentine and copaiba upon the urinary channels. JOAL.

**SEIFFERT** (Munich).—**Iodol.** *Munch. Med. Woch.*, 1887, No. 4.

THE author has treated cases of tubercular laryngitis with insufflations of iodol, as recommended by Lublinski; and prefers it to iodoform because of its absence of odour. He has also used it in ozæna. MICHAEL (Hamburg).

**SEHRWALD** (Jena).—**Percutaneous Injection of Fluids into the Trachea, Extension of them into the Lung, and Effect on the Lung and the whole Organism.** (Ueber die percutane Injection von Flüssigkeiten in die Trachea, deren Verbreitung in der Lunge, und Wirkung auf Lunge und Gesamtorganismus.) *Deutsches Archiv für klin. Med.*, Bd. xxxix., p. 163.

THE author summarizes his experiments in this manner:—

1. The perforation of the trachea of a dog with a Pravaz syringe is not dangerous, is easy, and not painful.
2. The reaction of the entry of fluids is cough. This can be diminished by warming the fluids, by narcosis, and by custom.
3. The volume of the introduced fluid may be, for a dog, 750 gr.
4. Efficient fluids are sublimat., 1 : 5,000; acid bor., 5 : 100; acid salicyl., 1 : 100.
5. By varying the position, the fluid can be introduced into every part of the lung.
6. The fluid pervades the alveoli, the peribronchial region, the bronchial glands, and the kidneys.
7. The absorption by the lung is quicker than that of the tractus intestinalis, or of the subcutaneous tissues.
8. The lung can absorb in five days four times its own weight.
9. The effect of drugs is therefore quicker if they are introduced by the lungs than by any other way.
10. Injecting into the lung is like injecting directly into the circulation.

The author hopes that it will be possible to use this method for the treatment of lung diseases. MICHAEL (Hamburg).

**WINSOR, L. C** (Spirit Lake, Ia.)—**Three Cases treated by Inhalations of Oxygen Gas.** *New York Med. Rec.*, January 29, 1887.

THE cases were:—

1. A boy with severe laryngismus stridulus and chronic bronchitis.

2. A woman with capillary bronchitis, dyspnœa, and cyanosis.
3. A girl with anæmia, headache, &c.

In the boy's and girl's case, the inhalations were of equal parts of oxygen and nitrous oxide, and amendment seems to have resulted. In the second case, pure oxygen was inhaled; and after three inhalations of five breaths each, the patient was comparatively easy, and the cyanosis disappeared. Inhalations were afterwards given every fifteen minutes, and at the end of eighteen hours were reduced to once an hour. The inhalations were supplemented by ordinary routine treatment.

**COAN, T. M.**—*The Therapeutics of Mineral Waters.* *The Medical Record*, January 8, 1887.

IN the course of a long paper, Dr. Coan refers to:—

1. Diseases of the respiratory tract, especially laryngitis, bronchial asthma, the earlier stages of phthisis, "and that ill-omened distemper, post-nasal catarrh." For this latter, the waters of Aix and Mont Dore are recommended, along with energetic local treatment.
2. The treatment of laryngeal and pharyngeal troubles. Aix, Ems, Royat, and the leading springs of Auvergne, and the Pyrenees, are the chief resorts. Dr. Coan recommends for "clergyman's sore throat," or laryngitis, the sulphur waters rich in sodium; or the alkaline, with chloride of sodium, such as Eaux Bonnes, Ems, Obersalzbrunnen, Neuenahr, Selters, and Sharon springs.
3. Beginning phthisis in nervous and sanguine temperaments. Mont Dore, Ems, Salzbrunnen, or Red Sulphur Springs, are to be preferred. In the phthisis of scrofulous temperaments, Salins, Kreuznach, Ischl, Kosen, Bourbonne-les-Bains, Rock-bridge Alum, Greenbrier Springs; for irritable or "erethic" scrofula, La Bourboule, St. Nectaire, and other springs of Auvergne.

**WATSON, SPENCER.**—*Three Instruments for the Removal of Polypi.* *Proc. Med. Soc.* Vol. IX. 1886.

THE author describes:—

1. A long slender polypus forceps, suitable for the removal of small polypi high up, or far back in the cavity, and more especially in those cases in which the operation is performed with the rhinoscopic mirror, and cocaine. The curve is so made that the point of the instrument can be observed all the time.



2. Delstanche's snare, with piano-wire instead of watch-spring for the snare, which latter is apt to break.

3. An improved ring-knife, the blade being flat on one side, and the edge lateral. The cutting edge extends only along the distal half of the ring, and the proximal half has no cutting edge.

4. In using the cautery, he guards it with a shield of crowquills, extending to the base of the loop, and varnished with shellac, and thus diminishes the danger of scorching the vestibule or nostrils.

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## DIPHTHERIA.

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**MONTEFUSCO, Dr. A.—A Case of Maniacal Diphtheria.** (*Un caso di Difterite Maniaca*). *Nota Clinica Archiv. Ital. Sc. Sc., Anno. VII., Fasc. I.*

THE author, after having remarked that in the course of diphtheria, psychical disturbances are rare, and exceedingly so attacks of real mania, and having referred to the case of acute diphtheritic mania of C. Lombroso as the almost solitary one on record, in which, however, the mania appeared some days before the development of diphtheritic symptoms, relates the history of his own case, which has greater importance from the mania appearing subsequently to the local manifestations. The phenomena which overshadowed the ordinary symptoms were psychical disturbances, sometimes sensory, such as acceleration, and inco-ordination of ideation, with abolition of the will, delusions of persecution and magnitude, and erotism; sometimes motor, with contraction of different muscular groups, involuntary, but consonant with the aberrant ideation, such as masturbation, &c. This condition lasted four days, and was accompanied with reduction of the temperature to 1° C. below normal. The local symptoms ameliorated with the cessation of the cerebral disturbance. The patient was discharged from the hospital after fifteen days.

MASSEL.

**CONCETTI, Dr. L.—A Case of Chronic Diphtheria.** (*Un Caso di Difteria Cronica*). *Archivio di Patologia Infantile, Anno IV., Fasc. 6.*

THE author believes his to be a case of the rare condition, chronic diphtheria, since it remained as it began for four months, presenting during that time only two short febrile periods. Cases of other

authors should be called rather *prolonged diphtheria*. The patient was three years old. The diagnosis of chronic nasal diphtheria was verified post-mortem, although it had been sufficiently established by the serous, sometimes bloody discharge, the production of false membrane on the right of the nasal septum and the paralysis of the velum, as well as by the fact that four indubitable cases of diphtheria of the fauces in intimate relations with the case broke out simultaneously.

MASSEL.

**TANVOLI, Dr. C.**—*Contribution to the Therapeutics of Diphtheria.* (Contribuzione alla Terapia della Difterite.) *Roma*, 1886.

THE author is enthusiastic for insufflations of sulphur, and gives some cases of cure by this means.

MASSEL.

**PATERNE.**—*Antiseptic Fumigations in the Treatment of Diphtheria.* (Des Vaporisations antiseptiques dans le Traitement de la Diphtherie.) *Thèse, Paris, January*, 1887.

AMONGST many substances, sulphur, bromine, chlorine water, ferric perchloride, gallic acid, salicylic acid, benzoate of soda, sulphate of quinine, chloral, thymic acid, etc., have been employed antiseptically. The author, however, recommends the following (Renou's mixture):

Phenic acid, 280 grammes  
Salicylic acid, 96        ,,  
Benzoic acid, 112        ,,  
Rectified spirit, 468     ,,

The antiseptic solution is to be placed on a stove as near the patient's head as possible. Twenty-four patients out of thirty, treated in the hospital in this manner, were cured.

Barbot (*Traitement de la Diphterie, Gaz. Hôpit., January* 20, 1887) speaks well of this antiseptic fumigation according to Renou's method.

JOAL (Mont Dore).

**IRVING, JOHN.**—(Heanor).—*Treatment of Diphtheria before and after the Larynx is involved.* (*British Medical Journal, January* 8, 1887.

IN cases uncomplicated by laryngeal symptoms the writer regards this as specific:—

R   Liq. ferri dialysati, ʒss.  
     Glycerini Acid. Carbol. pur. (B.P). ʒss.  
     Glycerini pur. ʒiss.  
     Syrupi simplicis, ʒiss.

Misce bene, et adde aquam ad ʒij.

One teaspoonful every two hours, and continue for eight days.

In a case of laryngeal diphtheria, the author uses

R Pot. Iod. gr. v.  
Sol. Nitro-glycer. (1 per cent), ℥ iv.  
Vin. Antimonialis, ℥ xlvii.  
Glycerini pur. ʒij.  
Aq. ad ʒij. Misce.

One teaspoonful every two hours.

**LANCRY.**—Contribution to the Study of the Contagium of Diphtheria. (*Contribution à l'Etude de la Contagien de la Diptherie*). *Thèse, Paris, December, 1886.*

THE following propositions are sustained :—

1. Diphtheria is contagious, and has a period of incubation.  
2. It is very probably inoculable. 3. The contagious element is with reason attributable to microbes. 4. Spontaneous genesis is scarcely probable. 5. Though the contagious principle is diffusible spontaneously in the atmosphere, this power is very limited. 6. It may be diffused in the air in a very feeble radius. This spontaneous diffusibility is the rule, when the source of the virus is in the channel of expired air, but the exception when the origin of the poison is otherwise. 7. The contagious element may be carried to a great distance by individuals and articles. It is not improbable that it retains its virulence for long, outside the organism. M. Lancry studies also the questions of prophylaxy, and thinks that a good children's hospital should be constructed and governed as a lazaret.  
JOAL (Mont Dore).

**ODENT.**—Pseudo-membranous Anginas in the course of Scarlatina. (*Des Angines pseudo-membraneuses au cours de la Scarlatine*). *Thèse, Paris, 1887.*

NON-DIPHThERITIC angina is not the effect of a contagium—it appears on the second or third day after the eruption; the false membrane arises on a crimson mucous membrane, and stands out, by its whitish colour on a livid base. There are extreme dysphagia, pharyngeal pain, acute and prolonged, great agitation, and delirium in children. There is less swelling of the neck than in true diphtheria, and in this latter the false membrane appears to be seated on a nearly normal mucosa.  
JOAL (Mont Dore).

**RENAULT.**—Diphtheria consecutive to Measles. (*De la Diptherie consecutive à la Rougeole.*) *Thèse, Paris, November 29, 1886.*

THE author has had many years' experience as "interne" in children's hospitals. He states that diphtheria is in certain circumstances (and principally in children's hospitals) a pretty frequent complication of measles. Though little different in symptoms from primary diphtheria, it is remarkable for its tendency to extension, and its frightful mortality. Patients succumb from diphtheritic intoxication, or broncho-pneumonia. Tracheotomy should be resorted to, as a last resource, in spite of the unfavourable prognosis. Therapy being so insufficient in this secondary form of diphtheritis, prophylaxis ought to be studied, and efficient measures of isolation adopted.

JOAL (Mont Dore).

## N O S E .

**SCHAEFFER.**—Rhinological Communications. (*Rhinologische Mittheilungen.*) *Monatsschr. für Ohrenheilk.*, 1886, No. 11.

1. Epistaxis. Three cases in which the bleeding spot was found to be on the septum, and the galvano-cautery effected a cure.

2. Polypi of the right antrum of Highmore. Ten polyps of the antrum were removed through the alveolus, after extraction of the tooth, with complete cure of the neuralgia.

3. A cyst of the nasal mucous membrane, as large as a nut, was incised and cauterized with chromic acid, a cure being effected in eight days.

4. Two cases in which adenoid vegetations of the recessus pharyngeus and fossa Rosenmulleri were removed.

5. Two cases in which obstinate aphonia was cured by treatment of the nose.

6. Two cases in which obstinate pharyngeal cough was cured by the galvano-cautery.

MICHAEL.

**HEYMANN** (Berlin).—The Origin of Nasal Pathological Conditions. (*Ueber die pathologische Zustände die vorder Nase ihre Entstehung finden können.*) *Deutsche Med. Zeit.*, 1886.

THERE is this in common between polypi and swelling of the mucous membrane—viz., that from time to time sensitive portions of the

mucous membrane come in contact with each other. The author never saw a case of reflex neurosis in which there was not at the same time friction and irritation between the surfaces. In this manner small polypi will cause reflex symptoms, which will disappear with the growth of the polyp. Chronic and constant swellings of the choanæ seldom cause neuroses, but acute and changing swellings often have this property. The author gives the case of a young lady in whom there was such difficulty of swallowing as to suggest œsophageal stenosis, but in whom there was no difficulty in passing a bougie. After the application of the galvano-cautery to the choanæ, the paræsthesia disappeared.

MICHAEL.

**RICHARDSON, B. W., M.D.—Epileptiform Seizures from Post-Nasal Polypus.** *Asclepiad*, January, 1887.

THE patient described her attacks as always being preceded by a feeling of something dropping into her larynx and "going the wrong way." The statement led to a post-rhinal examination, and the discovery of a large polypus. On the removal of this the seizures terminated, and have not recurred for eight years.

GREVILLE MACDONALD.

**MUNK (Duna-Sherdahely).—On a Case of Spasmodic Sneezing.** (Ueber einen fall von 'Niesskrampf.) *Wien. Med. Presse*, 1886, No. 51.

A GIRL of ten had suffered for some years with spasmodic sneezing so violent that no sleep was possible. There were intervals of comparative freedom. The author cured the case with applications of atropine and cocaine.

MICHAEL (Hamburg).

**LICHTWITZ, L.—Hystero-Genetic Zones on the Mucosa of the Superior Air Passages and the Sense Organs.** (Des Zones Hystero-genés observées sur la muqueuse des voies Aériennes Supérieures, et des Organes des Sens.) *Rev. Mens. de Laryngologie*, December, 1886.

EXPERIMENTS made in the practice of Prof. Pitres, of Bordeaux. The author has been able to locate, on the respiratory mucous membrane, zones, which he calls hypogenetic, lethargenic, and spasmogenetic. Of seven patients, of which he relates the cases, he found among six of them hysterogenetic zones. In all these cases the nasal fossæ were the seat of the spasmogenetic zones. Spasmogenetic and lethargenic zones existed in four of these cases; the posterior wall of the naso-pharynx was once the seat of a lethar-



genetic zone; once, the posterior aspect of the palate, and the opening of the Eustachian tube. It is necessary to be forewarned of these hysterogenetic zones, in order to avoid accidents in those cases where operations have to be performed, even as simple as possible, on the mucous membranes of hysterical subjects. JOAL.

**LABUS, CARLO.**—Means of Facilitating the Removal of Nasal Mucous Polypi. (Per Agevolare l'Asportazione dei Polipi Mucosi Nasali.) *Gazzetta degli Ospitali*, Anno VIII., No. 3.

THE author draws his conclusions as follows:—The removal of nasal mucous polypi, performed rhinoscopically with the snare, is an operation better borne than that with the forceps. Delicate, instead of clumsy, it is hence much less painful; respecting healthy parts, it does not cause undesirable lesions; and from the possibility of effecting ablations not feasible with the forceps, as well as, lastly, the hope of performing a complete operation and of producing a radical cure, make the operation in every respect preferable. The article is written with clinical precision, as well as with valuable clinical details, which occasionally are quite original. MASSEL.

**LANGE, VICTOR** (Copenhagen).—Remarks on the Operation for Polypi Choanarum, with a Description of a New Method of Operating on them. (Nogle Bemaerkninger om Operation af Choanalpolyper med Angivelse af en ny Operationsmethode.) *Ugeskrift for Læger*, Januar 1, 1887.

THE author understands by "polypi choanarum" polypi occupying the posterior nares, projecting more or less into the naso-pharynx. This form of polypi often being difficult to remove by the usual methods, the author has succeeded in four cases in removing them by the introduction into the nose, through the anterior nares, of an instrument, resembling somewhat a button-hook with a long handle. The hook is applied round the pedicle of the tumour by the help of the left forefinger introduced into the naso-pharynx. With a traction of the instrument the polypus is easily removed, and either pushed down into the naso-pharynx, or, if possible, through the nose by means of the finger. HOLGER MYGIND.

**VERDÓS, PEDRO.**—Clinical Data of the History of Syphilis of the Nose. (Datos Clinicos para la Historia de la Sifilis de la Nariz.) *An. de Otol. y Laringol.* 1886, Nos. X., XI.

THE author thinks that syphilis of the nose is rare. He has only found one case in a year, though from his position as a member of a

special hygienic commission he has seen daily from twenty-five to thirty "filles de joie." His fellow-professors have not seen even one case in the same time. This patient had active ulceration and a perforation of the soft palate, and recovered completely under iodide of potash, and iodoform and morphia insufflations to the nose, and painting the nose with iodine and iodide of potash.

RAMON DE LA SOTA Y LASTRA.

**GRAZZI, V.**—Parosmiæ, their Causes and Treatment. (Parosmiæ, sue Cause e Cura.) *Bollettino delle Malattie dell' Orecchio*, &c. Anno V., No. 1.

THE author alludes to perversions of the sense of smell, and especially to the perception of disgusting odours, which are always apparently subjective, although dependent upon abnormal nasal secretion. The state of this, however, is not commensurate with the account of it given by the patient. The author says it may be caused by disease of the nerve centres of the terminations of the olfactory nerves. He gives a description of the principal and secondary forms, and then speaks of the prognosis and treatment, the latter consisting chiefly of local and general sedatives.

MASSEL.

**HENDLEY, T. H.** (of Jeypore).—Nasal Calculus. *British Medical Journal*, December 11, 1886.

THE patient was admitted with a very painful swollen nose, and a large sinus on the left side of the organ, from which large quantities of pus were escaping. A probe detected a hard substance at the bottom of the sinus. In order to remove it, it was necessary to separate the nose from its attachments on the left side. The rhinolith weighed 720 grains, and was accurately moulded to the top of the nasal cavities on both sides. It measured two inches by seven-eighths, and had on section the appearance and almost the consistence of ivory. The patient had fallen on a stone twelve months previously.

GREVILLE MACDONALD.

**BARGELLINI.**—On the Prophylaxis of Sneezing and of Epistaxis. (Sulla Profilassi dello Starnuto e dell' Epistassi.) *Archiv. Ital.*

THE author, in a letter to Dr. Bobone, wishes to make known the two following methods of prophylaxis. To prevent sneezing he advises strong digital compression of the angle formed between the lip and nose. This he practised on a baby seven days old, who, in falling, cut the right ala of his nose, and was seized with such continuous sneezing as would have prevented healing of the wound by

first intention. The success of this means corroborates the theory of Baratoux concerning the seat of the sensitive zone. He urges the students to experiment on this theory in spasmodic sneezing. For the prevention of epistaxis, next, he advises the exhibition of snuff, a method which has produced most beneficial results with Dr. Ceasotti, and the distinguished anatomist, Prof. Vaselli, of Siena. MASSEI.

**FAIANO, Prof. A.—On Epistaxis. (Sull' Epistassi.)** *Archiv. Ital.*

THE author, after having referred to the forms admitted by Friederich, speaks of the etiological factors, according to the same author. Concerning vicarious epistaxis, he quotes the opinions of the various authorities, and declares his own belief that it depends on an inflammation of the nasal mucous membrane. In the same manner he explains rhinorrhagia during the course of a passive hyperæmia. He declares the diagnosis to be easy, and considers the prognosis favourable. He is inclined to consider habitual epistaxis in children as a symptom of latent tuberculosis.

Referring to local treatment, he considers the tampon, properly used, superior to astringents. Among so-called popular remedies, warm water appears to him scarcely fitting. He ends with the compilation of a good bibliography. MASSEI.

**ROUTIER, A.—Sarcoma of the Nasal Fossæ. Ablation—Consecutive Ozæna—Cure. (Sarcome des Fosses nasales. Ablation—Ozène consecutif—Guérison.)** *Rev. Chirurg., January, 1887.*

THE patient was a young man of twenty-four, with a large tumour of the nasal fossæ, proving microscopically to be sarcoma. An incision being first made through the arch of the palate, after fruitless trials with the cautery, the tumour was removed by a curette and the finger. During the operation the patient had the head hanging down, and thus lost little blood. JOAL (Mont Dore).

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## TONSILS, PHARYNX, &c.

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**FOX, HINGSTON.—Tonsillitis and its Relations to Scarlatina and Diphtheria.** *Proc. Med. Soc., Vol. IX., 1886.*

THE author thus sums up his conclusions:—

1. That there is a commonly occurring form of tonsillitis, symmetrical, varying much in severity, distinct from suppurative quinsy,

due to septic causes, often attacking several members of one household, and frequently prevalent at the same time as scarlatina and diphtheria.

2. That short-lived outbreaks of so-called infectious sore throat occur, associated with unsanitary conditions, the cases often varying much from one another, but intermediate in their general characters between tonsillitis and the two specific fevers.

3. That the throat lesion is the symptom most constantly present in both scarlatina and diphtheria, but its degree and character very greatly vary; that it is in some cases apparently identical in nature in the two fevers; and that it may be absolutely indistinguishable from the common form of tonsillitis first alluded to.

4. That there is some reason for regarding scarlatina and diphtheria as essentially forms of tonsillitis, which have acquired the power of infecting the system generally.

5. That the virus of these two fevers may probably enter the lymphatic system through the tonsil, producing tonsillitis as a primary effect.

6. That the specific character of these diseases is connected with the power of the poison-germ to overcome the resistance of the tissues so far as to reproduce itself in the human body without deterioration; that a certain series of lesions is thus set up before the poison is destroyed, and that in the meantime its multiplication affords a supply of *contagia* for the communication of the disease.

7. That this power of withstanding the resistance of the tissues and reproducing itself within the human body has probably been acquired under a process of evolution.

8. That there is nothing in the occurrence of scarlatina and diphtheria of wounds, and of other mucous surfaces than the fauces, to contravene the hypothesis that the poisons of these diseases in ordinary cases enter at the tonsils.

9. That the tonsils are absorbent glands, and that their function may not improbably be connected with the absorption of certain elements from the saliva.

**LEBRUN, A.** (Brussels).—**A Contribution to the Treatment of Acute Tonsillitis.** (*Contribution à la Thérapeutique des Amygdalites Aigues.*) *La Clinique*, February 13.

THE author bases his treatment upon the opinion that cold alone is powerless to produce the diseases commonly designated "diseases à frigore," the presence of microbes in the tissues being quite essential. He formerly prescribed antiseptic gargles, particularly boracic acid;

but now relies on iodoform-collodion applied to the throat once a day with a pencil. A case of phlegmonous tonsillitis was cured in a few days by this plan. CAPART.

**ATKINSON, F. P.**—Short Notes on the Causes and Treatment of some of the Diseases of the Tonsils. *Practitioner*, January, 1887.

**Ordinary Tonsillitis or Quinsy.**—Never epidemic, infectious, or contagious; the submaxillary glands are often involved from sympathy. *Causes:* Hereditary tendency; muscular and nervous exhaustion. *Treatment:* Effervescing citrate of potash, guaiacum and black currant lozenges. An iodine gargle (℥xx–xxv. of the tinct. to the ounce of water). Plenty of beef tea and milk, and 4 to 5 ounces of port wine daily. When pus has formed omit the citrate and lozenges, and trust to the gargle, &c.

**Follicular Tonsillitis.**—Often is epidemic, but apparently not infectious; rarely or never goes on to suppuration; is generally accompanied by neuralgic pains; the urine is non-albuminous; it is not succeeded by paralysis; the lymphatics of the neck are enlarged and tender; the patient is generally well in three or four days; under favourable conditions it readily assumes the diphtheritic type. *Cause:* Insanitary arrangements, especially when associated with a damp and heavy atmosphere. *Treatment:* Quinine and iron, and boracic acid, with glycerine and compound infusion of roses, as a gargle; or the application of boroglyceride to the various spots.

**Diphtheria.**—Is epidemic, contagious, and infectious; the urine is generally albuminous; it is attended, as a rule, with great exhaustion, and frequently succeeded by paralysis. *Cause:* Sewage-poisoned or germ-contaminated milk or water; defective sanitation. *Treatment:* Perchloride of iron and quinine in large and often-repeated doses; pigment of boroglyceride to the throat, or perchloride of iron and glycerine; port wine or brandy, and plenty of beef-tea and milk.

**Ulceration of Tonsil.**—1. **ASEPTIC FORM**, occasionally co-existent with quinsy, as a result of over-distension of the gland-surface. *Treatment:* Same as for ordinary tonsillitis. Quinine and iron do not seem to agree. 2. **SEPTIC FORM**—*a.* From *Syphilis*: Solid caustic to the tonsil; all other forms are made worse by caustic. *β.* *Scarlatina*: General treatment and boroglyceride locally. *γ.* From *Insanitation*: Give a mixture of dilute nitric acid, chlorate of potash, and tincture of perchloride of iron; a gargle of boracic acid, glycerine and infusion of roses; plenty of good liquid nourishment, and three or four ounces of port wine daily.



**Naso-pharyngeal Catarrh.**—*Cause*: Damp and exhaustion in predisposed persons, chiefly in those of strumous habit. *Treatment*: Chloralum, pure or slightly diluted, applied by a brush; a good dry elevated residence corrects the predisposition.

[It will be seen that the writer's methods of treatment are decidedly old-fashioned. His views upon follicular tonsillitis and naso-pharyngeal catarrh are particularly open to criticism. However, if his treatment is not exactly the means of doing most good, it has at least the merit of probably doing little harm.]

**DUNEY, Dr. F.**—On a rare Case of Pharyngeal Stenosis from Constitutional Syphilis, and an Anatomico-Pathological Study of Syphilis of the Liver and Spleen. (Sa di un raro Caso di Stenosi Faringea per Sifilide Costituzionale e Contribuzione Anatomico-Pathologica alle Sifilide del Fegato e della Milza.) *Rivista Clinica e Terapeutica, Napoli*, 11 and 12. MASSEI.

**TURNER.**—A Case of Retro-œsophageal Abscess, causing Death by Pressure on the Trachea. *Lancet, January 1, 1887.*

THE patient, a child aged three months, was under treatment for syphilis. After one temporary attack of dyspnoea, the child was seized, a few days later, with more severe dyspnoea, which increased to such an extent that tracheotomy became necessary. The child rallied somewhat for a time, but died a few hours later. Post-mortem was found a large abscess in the areolar tissue behind the œsophagus and lower part of the pharynx. It was bounded behind by the bodies and transverse processes of the vertebræ, which, however, were not diseased. The abscess extended from the level of the cricoid cartilage to within a quarter of an inch of the bifurcation of the trachea, the larynx and trachea being found quite healthy. The abscess probably arose from suppuration of the post-pharyngeal glands. It is worthy of remark that dysphagia, which is supposed to be the most prominent symptom of this condition, was entirely absent in this case.

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## LARYNX.

**WAXHAM, W. E.** (Chicago).—Intubation of the Larynx. *Phil. Med. News, January 1, 1887.*

REFERRING to the statement that if the trachea be plugged with membrane, and relief fail to follow the removal of the tube, immediate tracheotomy would become necessary, with less hope than if it had been done at first, and that with intubation no attempt can be

made to remove false membrane, Dr. Waxham mentions the fact that he has devised tracheal forceps for this purpose. He relates the following case:—On December 10 he was called to see a child of seven in the last stage of asphyxia from membranous croup. An intubation tube quickly introduced failed to give relief, no air entering the lungs. The tube was removed and again introduced, with the same result. Being then withdrawn, and the long tracheal forceps introduced by the mouth, a perfect cast of the whole trachea, and of the two large bronchial tubes to the extent of one and a half inches, was removed. The intubation tube now being introduced, respiration was at once established. As this accident will sometimes occur, every one performing intubation should have these forceps at hand. Dr. Waxham contends that intubation will save many lives which *could not be saved* by tracheotomy. He has performed intubation over a hundred times; fifty-two cases have been three years of age or under, a great many of them nursing infants, and he has had thirteen recoveries, or 25 per cent. One was an infant of nine months, another of fourteen, another of eighteen, another of twenty-two months respectively. "If any tracheotomist can show a better record with an equal number of cases at this age, we will then be convinced that intubation will not for the present supersede tracheotomy." One of the chief objections to intubation is the difficulty of nourishing the patient. To remedy this, Dr. Waxham has had tubes connected with very small heads, and uses a rubber collar with an artificial epiglottis attached. The collar prevents the tube slipping into the trachea, and being elastic, fits more perfectly into the larynx than the large metallic head. On swallowing, the epiglottis presses down the artificial epiglottis, and completely covers the opening of the tube.

**MASSEI, Prof. F.**—Introductory Lecture to the Course of Laryngology. (*Prelizione al Corso di Laringoiatria.*) November 30, 1886. *Riforma Medica*, No. 291.

INTRODUCING various clinical cases, Massei endeavours to point out the importance of laryngology for itself, and for clinical medicine in general. The patients brought forward are—one of primary tuberculosis of the larynx, one with laryngeal and pharyngeal syphilis, and a woman with double paralysis of the crico-arytenoidei postici from *tabes dorsalis*.

THE AUTHOR.

**GODET.**—Results of Surgical Intervention in some Carcinomas. (*Résultats de l'Intervention Chirurgicale dans quelques Carcinomes.*) *Thèse, Paris*, December, 1886.

BILLROTH performed total extirpation of the larynx, in 1873, for a

cancer; since this time the operation has been frequently done. It was first performed in France by Dr. L. Labbé, who has done it three times. Dr. Pean has also done it twice. It has now become a regular surgical operation, thanks to the introduction of Trendelenberg's canula and the galvano-cautery. Ninety-five cases are up to now recorded of total extirpation; in 12, death occurred within eight days, and in 19 in the eight days following, making a percentage of 33 deaths within the fifteen days following the operation. Adding 7 cases of later deaths, a total mortality is reached of 40 per cent. in this operation. In 22 cases of partial extirpation (generally unilateral), 8 deaths are recorded, of which 2 were after a second operation, for recurrence.

JOAL.

**ABBE.**—Notes on the Operative Closure of a large Laryngeal Fistula. (New York Surgical Society, December 22, 1886.)  
*Med. News*, January 15, 1887.

IN December, 1885, a man of forty-five came to be treated for an opening into the side of the larynx immediately above the vocal cords, into which the thumb could be thrust. It was caused by a fall upon a cobbler's knife, which cut through the left side of the thyroid cartilage. Attempts to close the fistula by suturing had failed. Eventually, with parings and ulcerations, a good deal of the left lateral half of the thyroid cartilage was sacrificed. The opening through the cartilage proper was  $\frac{3}{8}$ ths of an inch, and an extraordinary view of the vocal cords in action could be obtained. While the fistula was open, phonation was impossible; when closed, it was perfect. Tracheotomy was first performed, the glottis was then stopped through the fistula by a sponge attached to a string drawn out through the mouth. The edges of the fistula were pared. A broad elliptical space was then included between two incisions, somewhat wider, and extending obliquely downwards on the neck. A part of the included skin below the fistula was dissected up, for a flap to cover the hole, and stitched over the fistula by two rows of fine continuous catgut. The skin on either side of the neck was undermined, and slid over the flap so as to meet directly over its centre. A lateral slash,  $1\frac{3}{4}$  inches away, was made to relieve tension and allow insertion of a drainage tube. The patient made a good recovery, the tracheal tube being removed on the fifth day.

**LABBÉ, L.**—Extirpation of the Larynx. (Extirpation du Larynx.)  
*Congrès français de Chirurgie*, 1886.

THIS eminent surgeon has been the first to practise extirpation of

the larynx in France, in three cases in which the diagnosis of sarcoma and epithelioma had been previously made by Dr. Cadier. The operation is easy; it is indicated in cases of tumours relatively benign, sarcoma, and some epitheliomas. Tracheotomy is first performed some months before, in order to accustom the patient to wearing Trendelenberg's canula. JOAL (Mont Dore).

**LLOYD, J. (Birmingham).—Case of Extirpation of the Larynx without preliminary Tracheotomy.** *Lancet*, January 15, 1887.

THE patient, aged fifty-one, was a brass worker, and had suffered from dyspnœa with stridor, cough with expectoration, and attacks of difficulty of breathing for twelve months; great emaciation had now supervened. There was no history of phthisis or cancer, and no syphilis. The laryngoscope revealed a "cauliflower-like growth of the size of half a walnut springing from the left side of the larynx below the false cords." There were no enlarged glands, and the lungs were considered to be sound, nothing being found but "a few bronchial rales." Nothing in the steps of the operation call for comment, except that the trachea was divided with Paquelin's cautery, and instead of Hahn's or Trendelenberg's canula, a curved glass tube was introduced into the trachea for two inches, by which means blood was prevented from entering the wind-pipe. The whole larynx was extirpated, the trachea sutured to the skin, and a tracheotomy tube introduced. The patient died six days after the operation. "Examination of the larynx showed a large intra-laryngeal growth on the left side, probably of tubercular origin, and the necropsy revealed a condition of purulent bronchitis extending into the smallest bronchioles, infundibula, and pulmonary acini. Both lungs were everywhere studded with small miliary tubercles."

The author thinks the case interesting from the fact that no preliminary tracheotomy was required by his method of procedure. He also admits that extirpation of the larynx is "a serious surgical experiment." It is exceedingly difficult to understand why this "experiment," admittedly "serious," should have been done at all; or, indeed, why experiments of this nature should ever be undertaken upon the larynx. Where we have to deal with the internal viscera, surgery may come to the aid of medicine in an experimental manner, but with an organ such as the larynx, fully open to inspection, such a method of treatment does not appear to be justifiable. According to Mr. Lloyd the growth was situated above the vocal cords, *i.e.*, in a position favourable for removal *per vias naturales*. It is not easy to comprehend, moreover, why a cauliflower growth should at once be dubbed

"epithelioma," when it is well known to laryngologists that papillomata, especially if they attain any marked size, commonly assume the cauliflower form. On the other hand, epithelioma of the larynx has quite a different appearance. [Attention should be called to the fact that the growth was described by Mr. Lloyd, after the patient's death, as "probably of tubercular origin." If it was really "tubercular," it assumed an extremely rare, if not unique, form.] To return to the clinical aspect of the case, even if the growth could not have been removed by endo-laryngeal means, a portion could assuredly have been taken away for microscopical examination, when its true character would at once have been evident. But assuming that for some extraordinary and unexplained reason, it was impossible to detach the smallest particle to establish a diagnosis, it is remarkable that Mr. Lloyd did not perform partial, *i.e.*, one-sided extirpation of the larynx, instead of the major operation of total extirpation. In other words, it is in the highest degree remarkable that an operation comparatively safe, and which leaves a useful organ *in situ*, was not preferred to a very dangerous one, which, even if successful, places the patient in a most miserable condition for the rest of his existence. It is possible that Mr. Lloyd may have withheld information which would lead to a different view, but from the facts published we can see nothing whatever to justify the operation either from a medical or surgical point of view.

**MASINI, Prof. O.**—On a Tracheal Tumour removed *per vias naturales*. (Di un Tumore Tracheale Estirpato per le vie naturali.) *La Riforma Medica*, No. 275, 1886.

A FIBRO-MYXOMA from the first ring of the trachea, which during attempts at phonation protruded between the cords, was removed *per vias naturales* at one sitting after several attempts, anæsthesia being induced with cocaine. Some time afterwards there was no sign of recurrence. Masini used forceps specially modelled on the Mackenzie pattern; but the horizontal branch had the curve of Schrötter's forceps, and the vertical portion was longer. MASSEI.

**ARIZA, RAFAEL.**—Remarks on Tertiary Syphilitic Laryngitis. (Consideraciones Acerca de la Laringitis Sifilitica Terisaria.) *Anal. de Otol.*, &c., 1886, No. XI.

SYPHILITIC hypertrophy, called inflammatory, is extensive, diffuse, without well-marked limits from sound regions, of even surface, and darker red colour than the non-hypertrophied parts of the larynx. Its



favourite location is the epiglottis, the aryepiglottic ligaments, and the vestibule. Often unilateral, it begins sometimes in the centre of the epiglottis; it suddenly ulcerates in great extent, leaving a purulent, oval, and occasionally serpiginous or irregular form, with red, elevated edges. It may extend very deeply, and reach the perichondrium and the cartilage.

Gummy hypertrophy is well defined. Its size varies from a miliary granulation to a hazel nut; the surface is even if there is a single node, but nodulated if there are several. It is at first of the same, or a little redder, colour than the mucous membrane, but afterwards it turns yellowish; ulceration suddenly supervenes, cavernous and deep, and resembling the hole made by a hollow punch, with perpendicular and excavated edges. Several cases are related by Ariza.

RAMON DE LA SOTA Y LASTRA.

**ARIZA, RAFAEL.**—On Partial Laryngeal Paralyses. (*De las Parálisis Laringeas Frustrados.*) *Mem. Leidas en la Socied. Espanola de Laring., Ot., y Rhinol.* Tomo I., 1886.

THE author studies those cases in which, with apparently sound larynx, the voice is feeble, lost, or aphonic momentarily. It is sometimes dependent upon one-sided contraction of the adductors, through loss of their tonicity. This condition is revealed by the slight deviation at the anterior end to the right or left side, from the straight line formed by approximation of the vocal cords during phonation. At other times it is due to diminished force of contraction of the abductor muscles of one side, as is shown by the arytenoid cartilage of one side retiring from the mid-line more slowly than the other, after phonation; or by its remaining stationary for a moment, or by its arrest midway, arriving at complete abduction only when the patient has taken deep inspirations. If there is a partial paralysis of the tensor muscles, the vocal cords appear lax; if of the thyro-arytenoidei, a separation is seen, now in one, now in another portion of the glottic line. In all these cases there is not true paralysis, since the conditions are not stable and constant; but that it is not a transitory accident is shown by the obstinacy of the affections.

RAMON DE LA SOTA Y LASTRA.

**HALL, DE HAVILLAND.**—A Case of Aneurism of the Aorta. *Proc. Med. Society*, Vol. IX., 1886.

THE left cord was motionless in the cadaveric position. Eight months before, patient could hardly speak at all, due probably to pressure on the left recurrent leading to immobility of the cord, and on phonation

the right cord coming to the median line, leaving a gap. Compensation took place afterwards, and the right cord passing the median line, the voice improved. The pressure in this case seems to have affected both abductor and adductor fibres, the cord at once assuming the cadaveric position. Thus, there was no cough, stridor, or dyspnoea, and the voice was falsetto. In three cases examined successively, the author found cadaveric position in two, and partial adduction of the cords in one.

**MASINI, Prof. O.—Anatomo-Pathological Observations on a Case of Primary Cancer of the Larynx.** (Su di un Caso di Cancro Primitivo del Laringe Osservazione Anatomo-patologico.) *Archiv. &c., Anno. VII., fasc. I.*

THE anatomical specimen, which the author investigated in the Laboratory of General Pathology in Genoa, belonged to the Anatomo-Pathological Museum of that University. It was the larynx of an adult man who had died two years previously with symptoms of laryngeal stenosis. It presented at first sight an enormous tumour, in relation with the *rima glottidis*. Macroscopical examination did not reveal anything further than a certain thickening of the inter-arytenoid fold, and a superficial irregularity about the wide base of the tumour. Microscopically, the following were the prominent points: in some places a covering of cylindrical epithelium; in others, infiltration of young cells towards the centre, characteristic cylinders scattered here and there, and collections of epithelial cells, smaller at the periphery than the centre, and disposed concentrically; lastly, a fibro-cellular stroma, in many spots infiltrated with round cells, as though from the proliferation of the same connective stroma. Not only was the examination of the two laryngeal nerves negative, but also that of the lymphatics.

MASSEI.

**JURASZ (Heidelberg).—Splint of Bone in the Larynx of a Twenty-two-months-old Child found by Laryngoscopy and removed.** (Knochenstück in der Kehlkopfhöhle eines 22 Monate alten Kindes laryngoscopisch nachgewiesen und entfernt.) *Monatschrift für Ohrenheilkunde, &c. 1886, No. 12.*

AFTER aspiration of a splint of bone the child became hoarse, had an attack of dyspnoea, cough, and difficulty of swallowing. Laryngoscopy was not possible without narcosis. Under chloroform the Whitehead speculum was applied, but it was impossible to see anything in deep narcosis. But as the child half recovered from the narcosis, laryngoscopy became easy while it was crying. The splint could

be seen between the right arytenoid and the left ligamentum vocale. The bone was now extracted with forceps. It is the first case of extraction of a foreign body in a child younger than three years. This operation can only be performed during semi-narcosis.

MICHAEL (Hamburg).

**McCOY, A.** (Philadelphia).—**The Galvano-cautery in the Treatment of Papilloma of the Larynx.** *Med. News, January 1, 1887.*

THE author employs a finely pointed electrode, insulated well down to the point, and made of copper to obtain flexibility. With this instrument he has been able to destroy growths very difficult of access with ordinary forceps, and even to extirpate subglottic growths only coming into view on deep inspiration. The cautery point must be heated to white heat, and in this manner reaction is avoided and contact only momentary. The author relates a case of laryngeal growth extirpated by him in this manner.

**SOTA, RAMON.**—**On Crico-Arytenoid Arthritis.** (*De la Artritis Crico-Aritenoidea.*) *Mem. leídas du la Sociedad Española de Laring., Otol., y Rhinol.* Tomo I., 1886.

A MAN of twenty-six, after drinking cold water while sweating, felt pain on speaking, coughing, and swallowing. The voice was hoarse, the palatal and laryngeal mucosa were red and granular, the base of the right arytenoid cartilage tumid and red, its movements on the cricoid cartilage very limited, and during inspiration it hardly separated from the mid-line, whilst during phonation it remained in front of the left arytenoid, this latter going further over than natural. The right vocal cord was relaxed, the internal edge undulated, and its vibrations abolished. There were no constitutional symptoms, and no history of disease. Dr. Sota diagnosed arthritic crico-arytenoid inflammation. The patient recovered in a month by rest, sudorific drugs, and the application to the larynx of a solution of chloride of zinc. The author discussed the causes, symptoms, prognosis, and treatment of this class of affection.

RAMON DE LA SOTA Y LASTRA.

**TISSIER.**—**Glottic Stenoses in the Tubercular.** (*Sténoses Glottiques chez les Tuberculeux.*) *Annal. Mel. Oreilles Larynx.* January, 1887.

THESE are stenoses due to the approximation of the vocal cords to the median line. The explanation of this condition is either: 1st, paralyse of the dilators; 2nd, spasm of the adductors. Tissier thinks that the recurrent is affected by peripheral neuritis, or gang-

lionic compression. This nerve is composed of pneumogastric and spinal accessory fibres. The former fibres are smaller in quantity, their excitability is lost sooner than the spinal fibres, and it is not irrational to suppose that they submit first to the "*contrecoup*" of ganglionic compression, or of neuritis, and that they may be damaged, while the spinal filaments preserve their action. The influence of these latter predominating, the glottis will be closed and the cords approximated. JOAL (Mont Dore).

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## NECK, &c.

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**WEIR.**—**Tumour of Thyroid removed by Socin's Method.** *New York Surgical Society, December 8, 1886 (Med. News, January 25, 1886).*

SOCIN'S operation of enucleating the thyroid tumour now embraces over fifty cases, without any cachexia strumapriiva following. In Dr. Weir's case the patient was a dwarf of twenty-one, mentally defective, and with an appearance of commencing myxœdema. The thyroid gland was exposed, cut through, and the tumour enucleated with the end of a scalpel and the finger nail, the venous oozing being checked by clamps and ligatures, and the cut gland edges sewed together except at the lower end, to allow the insertion of a drainage tube. Secondary union followed. The tumour was friable, and divided into lobes, like a compound racemose gland, with tubes and ducts lined with cylindrical epithelium, and the whole enclosed in a delicate fibrous capsule. The diagnosis was adenoma.

**DE BURINE.**—**Considerations on Goître, dependent on Pregnancy and Accouchement.** (*Considerations sur le Goître, dependant de la Grossesse et de l'Accouchement*). *Thèse. Paris, December, 1886.*

THE author relates nineteen observations, of which three are original. The thyroid gland is related to the female genital organs sympathetically. Uterine excitements are reflected in this organ so greatly that a sign of virginity has even been sought for in the volume of the neck. Thyroid hypertrophy has been noticed at the time of puberty, or the menopause. Goîtres have even appeared at each monthly period, disappearing on its cessation. Pregnancy is analogous. We can imagine that with the uterus, the vagina, the round ligaments, and the breasts, the thyroid gland acquires an

access of vitality, hypertrophying, becoming more vascular, and the seat of hypergenesis of lymphoid follicles, such as are found in all the female organs in a state of gravidity. The author protests against thyroidectomy during pregnancy, as a dangerous operation.

JOAL (Mont Dore).

**DUGUET.**—*Goîtres and Interstitial Medication with Iodine.* (Goîtres et Medication Iodée Interstitielle.) *Procès agréé à la faculté Med. de l'Hôp. Lariboisière. Paris, December, 1886.*

TOTAL extirpation of the thyroid being followed with such grave sequelæ (myxœdema) the author thinks that treatment should be limited to injections with tincture of iodine, especially as partial extirpation does not forbid a recurrence.

The author cites the cure of twenty-one cases out of thirty-four treated by him with iodine injections; of the other thirteen, seven cases were ameliorated; the remainder are incomplete.

It is not the character of the goitre, cystic, parenchymatous, &c., but the age of the tumour which will influence the result of treatment. Old goîtres remain refractory.

Tincture of iodine acts, 1st, by the irritant action of the alcohol; 2nd, by the specific action of the iodine. Dr. Duguet has made 266 injections without accident.

JOAL (Mont Dore).

**GALLOZZI, Prof. C.**—*Echinococcus Cysts in the Thyroid Gland.* (Ciste da Echinococco della Glandola Tiroide.) *Riforma Medica, No. 288.*

A MOST interesting case, in which, while emptying the cyst, there came away pieces of tissue belonging apparently to the maternal vesicle, although the chemical and microscopical examinations have not been concluded.

MASSI.

**WIGNALL.**—*Research on the Micro-organisms of the Mouth.* (Recherches sur les Micro-organismes de la Bouche.) *Archiv. Physiologie, December, 1886.*

BESIDES the micro-organisms already known, viz., staphylococcus pyogenes albus, staph. pyog. aureus, leptothrix buccalis, bacterium termo, bacillus subtilis, vibrio rugula, the author describes a coccus which has been recognised by Escherich in the feces of infants, nourished as yet only with maternal milk; it occurs in the form of a small sphere, of about  $0.5 \mu$  diameter, rarely in the form of chains, single and isolated. Then follows the study of—1, a micro-organism, occurring as a pretty large bacillus, of variable length, rectilinear, and sometimes forming chains; 2, small short rods, of variable dimen-



sions, and secreting a strongly adhesive substance; 3, of a short, thick bacillus, with slightly rounded extremities, and becoming clear at the centre when the culture is old. The author also describes ten new organisms of the mouth, which brings their number up to sixteen.

JOAL.

**PONCET.**—**Tubercular Ulceration of the Tongue. Treatment by Eucalyptol and Lactic Acid.** *Lyon Médical, January, 1887.*

A CASE of a patient presenting tuberculosis of the right apex, similar ulcerations of the tongue, and digital ulcerations of the same nature. Tubercle bacilli were found in these latter. The patient had been put under a course of treatment by eucalyptol and lactic acid (80 per cent.). The ulcerations of the fingers were dressed with lint dipped in eucalyptol, twelve to fifteen days after the wounds were nearly completely cicatrised, but this was only in appearance, since the skin was infiltrated with fungosities below the epidermic secretion. Dr. Poncet thinks that eucalyptol acts as a desiccator of the secretions, but there is no proof that it is a microbe destroyer. As to lactic acid, used for the ulceration of the tongue, it produced much pain, lasting for an hour after the application, but no appreciable amelioration of the condition.

JOAL.

**COMBE (Paris).**—**Catarrh of the Maxillary Sinus. The Limits of its Curability. Its Treatment by Antiseptic Powders, and especially by Iodol.** (Catarrhe du Sinus Maxillaire. Les Limites de sa Curabilité. Son Traitement par les Poudres antiseptiques et en particulier par l'Iodol. *Second French Congress of Surgery, 1886.*

THE only treatment adopted for this complaint, is that of trephining the cavity; introduction of a metal drainage tube; and the application of antiseptics by powder or irrigation. Injections introduced through the nasal fossæ are of no effect. M. Combe thinks that in certain cases of obstinate ulcerations of the turbinated bodies, beneficial results are obtained by injections of carbolised glycerine, and insufflations of iodol in powder through the sinus made by trepanning.

JOAL.

**BOURRÉE.**—**Contribution to the Study of Acute Sublingual Ranula.** (Contribution à l'Etude de la Grenouillette aigue Sublinguale.) *Thèse. Paris, December, 1886.*

THE author examines the different theories as to production of ranula—1st, dilatation of Wharton's duct; 2nd, dilatation of a sublingual gland; 3rd, acute œdema, or congestion of the floor of the

mouth; 4th, dilatation of the Blandin-Nühn gland; 5th, dilatation of Fleischmann's bursa, and comes to the conclusion, that ranula is produced by the rupture of Wharton's duct, oftenest, and to the consecutive inundation of Fleischmann's bursa. The mechanism of its production comprises three factors—1st, obliteration of the excretory duct; 2nd, dilatation of Wharton's duct; 3rd, rupture of the duct, and effusion of the liquid into a closed, pre-existing cavity. The causes from which acute ranula may arise are numerous and variable: formation of a calculus in the excretory duct, a tumour compressing its orifice,

**HAWARD, W.** On some forms of Defective Speech. *Lancet*, January 15, 1887.

A CLINICAL lecture on the vocal education of patients who have been operated on for cleft palate, highly-arched palate, post-nasal growths and nasal polypi, with remarks on stammering, &c.

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## REPORTS OF SOCIETIES.

### Academy of Medicine, Ireland.

December 3, 1886.

*Stricture of the Œsophagus.*—Mr. Edgar Flinn exhibited the œsophagus and stomach of a man who died from epithelioma of the œsophagus. The œsophagus was very much narrowed in its lower fourth, and the most contracted part of the stricture was found to be about three-quarters of an inch from the cardiac orifice of the stomach, and would hardly admit of a small-sized pen-handle being passed through it. The stomach was enormously dilated—so much so that when the abdomen was opened it appeared to fill up the entire cavity. A large fruit-stone was found immediately contiguous, and somewhat beneath the pyloric orifice, imbedded in a diverticulum. This fruit-stone must have lain in this diverticulum for a long time, the post-mortem appearances showing that its passage through the œsophagus would have been well-nigh impossible during the last two years of the patient's life; from its position near the pylorus, it exercised a considerable pressure on the pyloric orifice, and thus, in great measure, the great dilatation of the stomach was to be accounted for.

### Clinical Society of London.

January 14, 1887.

Mr. MAYO ROBSON (Leeds) read a paper on a method of treating thyroid cysts, in which he advocated antiseptic incision and stitching the edge of the cyst to the skin, draining for a short time under an antiseptic dressing, and then packing with zinc lotion and lint. An interesting discussion followed, with reference chiefly to risks from hæmorrhage.

### Harveian Society.

January 6, 1887.

Dr. MORTON read a paper on "The Analogy between Croup and Asthma," the object of which was to compare stridulous laryngitis—to which he gave reasons

for thinking the name of croup should be confined—and spasmodic asthma. The sudden nocturnal invasion, the diurnal remissions, the cessation of the liability to croup, as well as to asthma, &c. &c., showed that croup could not be a real laryngitis with paralysis according to the accepted pathology, but a paroxysmal dyspnoea from disturbed innervation of the larynx, as asthma was of the bronchi.

**Pathological Society of London.**

*February 15, 1887.*

Mr. CLUTTON showed a specimen of retropharyngeal abscess, which opened by three round orifices into the œsophagus, and by one into the larynx, below the vocal cords, and lead to acute laryngitis. The first symptom during life appeared to have supervened suddenly after an epileptic fit, and consisted of pain and swelling of the neck, with expectoration of mucopurulent fluid; deglutition but not respiration was impeded. The man died eventually of broncho-pneumonia.

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## REVIEWS.

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**A Guide to the Examination of the Nose, by E. CRESSWELL BABER.<sup>1</sup>**

THIS small book, of about 160 pages, forms a useful and accurate guide to the student about to commence rhinological observations. The work is eminently practical, the methods of examination are carefully detailed, the illustrations (many of which are original) are numerous and well executed, the type is clear, and the “make-up” good. The chapter dealing with the diagnosis of the common nasal diseases is somewhat too meagre to be of much service to the practitioner. This and also the omission of any indications for treatment of these conditions is, however, in accordance with the author's plan to limit himself to the production of a guide to the practical examination of the nasal cavities. Judged in this light, the work merits only commendation.

**BERGER (Graz) and TYRMAN (Graz).—The Diseases of the Sphenoidal and Ethmoidal Sinuses, and their relation to Diseases of the Eyes.<sup>2</sup>**

No work up to this time has dealt with the diseases of these regions. Rhinological works refer to them but briefly, and a book such as the above supplies a want. Affections of these sinuses are rare, and the authors have searched ancient and modern literature in order to present a complete picture of the subject. An interesting case is mentioned of defect in the sphenoid bone, which may be the cause of an error

<sup>1</sup> London: H. K. Lewis, 1886.

<sup>2</sup> “Die Krankheiten der Keilbeinhöhle, und des Siebenlabyrinths, und ihre Beziehungen zu Erkrankungen des Sehorgans.” With 9 Drawings. Wiesbaden, 1886. J. F. Bergmann.

in the diagnosis of an encephalocele from a naso-pharyngeal polypus. A case is related in which, in consequence of this error, death followed an operation by supervention of meningitis. Of the dangerous, and often fatal, suppurative inflammation of the ethmoidal sinuses the authors collect some very instructive cases. The two cases of suppurative inflammation of the sphenoidal sinuses, mentioned by Mackenzie, are here quoted. Michel's opinion that ozaena is due to catarrh of these sinuses is shown to be incorrect. Caries and necrosis of the sphenoid are often combined with similar affections of the jaw bone, and followed by amaurosis. All the cases which can be collected of abscess, polypus, enchondroma, osteoma, benign and malignant tumour, having special reference to troubles of vision, are here related. Fractures of these bones are generally combined with fractures of the orbit, jaw, and nose. The authors describe the parasites of these regions. The concluding chapter, in which the writers review the different symptoms caused by caries, necrosis, and neoplasmata, and their differential diagnosis, is of great interest. The little book has been elegantly produced by the publisher, and must be cordially recommended. MICHAEL (Hamburg).

**HERZOG, JOSEF** (Graz).—**Acute and Chronic Catarrh of the Naso-pharynx, with special reference to Neurotic Coryza (Rhinitis Vasomotoria).**<sup>1</sup>

THIS is a short and excellent *résumé* of the present state of our knowledge of these affections. We cannot at all agree, however, with the author's proposal to abolish the term "ozaena." This suggestion is made in consequence of the view he takes that ozaena is only a form of catarrh with fetid secretion. It is possible that this may be the pathological character of this affection, but as writers are by no means agreed as to the meaning of this condition we are assuredly not justified in adopting the author's view, which would assign to the term ozaena a very definite pathological meaning.

The author does not believe that the hypertrophy of the tonsils occurring in young children is congenital, as Bresgen maintains, but believes that the condition is produced by constantly recurring catarrhs, causing overgrowth of the adenoid tissue. Scrofula is said to be the most important etiological factor in the production of chronic nasal catarrh, and damp and moist air of cellar dwellings similarly for rhinitis fetida. Affections of the teeth can also give rise to this latter condition. The symptomatology of chronic catarrh is

<sup>1</sup> "Der Acute und Chronische Nasenrachenkatarrh, mit besonderer Berücksichtigung des nervösen Schnupfens; Rhinitis Vasomotoria." Second revised and enlarged Edition. Graz: Leuschner und Lubensky, 1896. 67 pages.

very complete, but would have been clearer if the author's views on "ozæna" had not been so singular. He draws attention very truly to the irritation of the mucous membrane of the inter-arytenoid regions coincident with chronic naso-pharyngeal catarrh, and which is not removed until the naso-pharynx is medicated.

These catarrhs are associated with decrease of strength and general loss of health, due to disorder of the stomach from swallowing the mucus, and irritation of the bronchi from respiring directly through the mouth. The author differentiates two forms of reflex neuroses. One is always combined with chronic rhinitis; the other is only observed in neurasthenic individuals, and is without pathological nasal conditions. This latter is called by the author "rhinitis vasomotoria." It is characterised by sudden swellings of the choanæ; temporary congestion with profuse secretion, and the author regards it as an affection of the sympathetic similar to the physiological "paralytic secretion" of Bernard.

Hay fever is also a variety of this condition. Sexual irritation—in women, menstruation and the climacteric; in men, onanism—is an important etiological factor in the production of vasomotor rhinitis. General treatment, such as Fowler's solution, gives better results than local medication. The author warns against the use of Weber's douche, and recommends applications by the spray. He has had excellent results from the use of boric acid insufflations with nitrate of silver. He has ceased to use iodoform. "Eczema aditus narium" is only to be cured by removing the catarrh. For general treatment of scrofula he recommends the iodine waters.

MICHAEL (Hamburg).

**MOLDENHAUER, W.** (Leipzig).—**The Diseases of the Nose and neighbouring parts, and of the Naso-pharynx, including the Methods of Examination. For the use of Practitioners and Students.**<sup>1</sup>

CONSIDERED as a work intended not for the specialist, but for the practitioner and student, this book must be pronounced excellent. The tendency, which is irresistible to some writers, to dwell too minutely on certain points more particularly interesting to themselves than to the practitioner, is here avoided. The section on the anatomy and physiology of these regions contains some good illustrations. The writer prefers the Duplay-Charrière speculum, and recommends the use of Zaufal's tubes where possible. We are rightly warned

<sup>1</sup> "Die Krankheiten der Nasenhöhle, ihrer Nebenhöhlen und des Nasenrachenraums, mit Einschluss der Untersuchungstechnik. Zum Gebrauch für Aerzte und Studierende." With 25 illustrations in the Text. Leipzig: C. W. Vogel, 1886. 198 pages.



against the abuse of the nasal douche, and the too frequent application of astringent and caustic applications, by reason of injury to olfaction. Chloride of zinc is strongly recommended for cauterising purposes. The chapters on diseases of the introitus and acute and chronic rhinitis introduce nothing new. We believe that the author is right in treating ozæna, or rhinitis fœtida, in a special chapter, and not as a part of catarrh. All that is necessary is said as to diphtheria, scrofula, lepra, lupus, and rhinoscleroma. The chapter on syphilis is very extensive, especially in its pathology. The author only uses the galvano-cautery to mucous polypi when he has failed to operate successfully with the cold wire. Small polypi and mucous degenerations are to be cauterised with chromic acid.

The author has seen six cases of circumscribed caries of the nasal bones without dyscrasic cause. They were all successfully treated with the sharp spoon. The author does not recommend chloroform during the removal of adenoid vegetations, where it can be dispensed with. He uses cutting forceps. Moldenhauer agrees with Hack in the opinion that swelling of the cavernous tissue can produce reflex neuroses, and he treats such tumefactions with the galvano-cautery. The author treats hydrops and abscess of the antrum of Highmore by opening the cavity, through the extraction of a tooth. The book is well produced, and the illustrations are above the average.

MICHAEL (Hamburg).

**HELMKAMPF** (Bad Elster).—**Diagnosis and Treatment of Diseases of the Mouth and Pharynx; and of Diseases of the Teeth.**<sup>1</sup>

THE German phrase, "Um einem längst gefühlten Bedürfniss abzuheffen," expresses our first impression of the title of this book. We often find it remarked that diseases of the teeth cause affections of the pharynx, larynx, nose, ear, and eyes, either by continuity or in reflex manner. The laryngologist and rhinologist ought to know something of the ordinary diseases of the teeth and gums. This book is written solely for such an one, and not for the dentist. The author shows how dental caries may produce swelling of the nasal mucosa, and inflammation of the antrum of Highmore; and how the swallowing and inhalation of infected particles and air may give rise to diseases of the intestinal and respiratory tracts. The chapter dealing with bleeding from the gums in scurvy and after tooth extraction is of great interest. The second part of the book deals with diseases of the gums, mouth, and tongue. The various forms of stomatitis are

<sup>1</sup> "Diagnose und Therapie der Erkrankungen des Mundes und Rachens, sowie der Krankheiten der Zähne." Stuttgart: Enke, 1886. 243 pages.

passed under review, the description of the scorbutic form being especially good. Attention is drawn to the fact that diseases of the teeth and gums frequently cause a universal stomatitis, which is curable with the removal of the affection of the former. The author finds in absolute alcohol the best treatment for gangrene of the mouth. Chapters on noma and tongue diseases follow. Of interest is an appendix, in which are included some remarks upon the daily habit of scraping the tongue indulged in by many persons. This habit is pernicious, since it can by irritation lead to ulceration, and even to carcinoma. The author, however, forgets this good advice when in the chapter dealing with soor and leptothrix he recommends the mothers to cleanse their babies' mouths after each feeding. Much of interest is contained in the sections dealing with parotitis and sialorrhœa. The author communicates a very rare case of intermittent sialorrhœa, and also cites in detail two cases of complete suppression of saliva, described by Buxton and Baynes.

MICHAEL (Hamburg).

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## NOTES.

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**We have the pleasure** to announce the addition to our staff of Dr. Constantin Karwowski, of Warsaw, who will keep us informed in all subjects appertaining to our specialty in the Polish language.

**The French Society of Otology and Laryngology** will meet at Paris on Wednesday, April 13, at 8.30 p.m., at the Mayoralty of the first district, Place Saint Germain, Auxerrois. Communications are to be addressed to the Secretary, "Rue d'Amsterdam, 72 bis," before March 10. All Memoirs will be made in French.

**Electrolysis.**—A further development of the use of the intubation tube has been made by Dr. Waxham, of Chicago. In a case of membranous croup in which there were very severe symptoms of laryngeal stenosis, Dr. Waxham connected the tube with the negative pole of a battery of eight cells. The symptoms are said to have improved, and the child to have recovered.

**A New Journal.**—The first number of *La Pratique Médicale* was issued in Paris on February 15, 1887. It is published under the direction of Drs. Baratoux, Jonin, and A. Malécot. Its chief aim is to give a series of reviews of medical and special subjects, in which the editors hope, by extracting the wheat from the chaff, to lay before their readers the practical deductions to be drawn from a large number of works under review. We have no doubt that the laryngological sections will be carefully done under the able direction of Dr. Baratoux, himself a distinguished and industrious worker in this field.

**The International Medical Congress.**—The *Berliner Klinische Wochenschrift* in an editorial article expresses the opinion that though Europeans will not see a representative gathering of American physicians, and many well-known names

will be absent, yet the visitor will be well repaid in the interesting sights and experiences which will be presented to him. We believe that a fair contingent of Englishmen will visit the Congress, since the occasion affords an opportunity for many to make the trip under favourable auspices, and to exchange social courtesies with their American *confidés*, who would not be tempted to cross the Atlantic without some such object in view as a Congress.

**Rectal Injections of Gas.**—"A few years ago we were using respirators and inhalers in the treatment of phthisis and chronic bronchial troubles, and the journals were filled with reports of wonderful results obtained by this method. Ask the nearest pharmacist, and he will tell you that now the sales of respirators in a year are not equal to what they were in a week, and that practically the method has been abandoned. Meanwhile the fight goes bravely on, and as the enemy has not yielded to the attack *a fronte*, the tactics have changed, and we are asked to assault him *a tergo*" (*Med. News*, January 29, 1887). From the same article we learn that the plan has for some time been in use at the Philadelphia Hospital. The general opinion of this means of treating chronic bronchitis, asthma, and phthisis, is distinctly favourable, and though a decidedly inelegant method of medication, it is perhaps worth a trial. It is, however, not improbable that the enemy will show as much fight when thus attacked, and though at present caught napping by this unaccustomed mode of onslaught, will soon put himself into as resistant a position as before. Sulphuretted hydrogen, alone, or combined with carbonic acid, seems to be the best, about one quart being injected at each sitting. It is scarcely likely that this mode of treatment will become very popular outside of hospitals.

**Books, Pamphlets, &c., received.**—*Edinburgh Medical Journal*. *Gazette des Hôpitaux*. *Progrès Médical*. *La Pratique Médicale*. *Philadelphia Medical News*. *Bolletino delle Malattie dell' Orecchio*, &c. *Deutsche Med. Woch.* *Deutsch. Med. Zeitung*. *Münchener Med. Woch.* *Breslauer Aerztliche Zeitsch.* *Correspondenzblatt Württemberg Aerzte*. *Prager Med. Woch.* *Internationale Klin. Rundschau*. *Wiener Med. Presse*. *Revue Médicale de la Suisse Romande*. *Jahrsbericht für die Krankheiten der Nase und des Kehlkopfs*: Frankel. *Reflex Neurosen*: Böcker. *Sonlirung der Steinbeinhöhlen*: Jurasz. *Rhinologische Mittheilungen*: Schäffler. *Nasenkatarrh*: Herzog. *Diagnose und Therapie der Erkrankungen des Mundes*, &c.: Helmkamp. *Krankheiten der Nasenhöhlen*: Mollenhauer. *Krankheiten der Keilbeinhöhle*, &c.: Berger and Tyrmann. *Aphonia und Dyspnæa Spastica*: Krause. *Reflex Neurosen*: Krause. *Verkrümmungen der Nasenseidewand*: Hubert. *Nasentypen*: Heymann. *Reflex Neurosen*: Heymann. *Kehlkopfcarcinoma*: B. Fränkel. *Casa di Cisti della Borsa Faringea*: Masucci. *Report on Rhinology*: Stucky. *Protritic Catarrh*: Stucky. *Ann. des Mal. de l'Oreille*, &c. *Gazeta de Oftalmologia*, &c. *The Canadian Practitioner*. *Therapeutic Gazette*.

*Letters relating to the Editorial business of the Journal are to be addressed "To the Editors."*

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No. 4.

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TRACHEOTOMY IN CROUP AND  
DIPHTHERIA.

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TRACHEOTOMY in croup and diphtheria depends for its success upon the prevailing character of the epidemic disease, the age of the patient, and the circumstances by which he is surrounded, the stage of the affection at which the operation is performed, the methods and accidents of the operation itself, and especially upon the treatment of the patient after the operation. The literature of this subject is of vast extent, and though we cannot hope to deal with such a subject exhaustively, it will be our object to bring home to the practitioner certain facts which will interest him from a practical point. The nature of the epidemic disease, its occurrence in sporadic or epidemic form, and the prevalent character of this latter, have a very definite relation to the success of the operation. In estimating the value of statistics, which after all can only be considered to have an approximate value, it appears to us that this fact is not sufficiently borne in mind. Just as we have many clinical varieties of croup and diphtheria, we have from time to time undoubtedly, various telluric, atmospheric, epidemiological and other factors to deal with, which materially alter the value of our conclusions as to the success of our treatment, and the data to be drawn from statistics. Thus, no reliable conclusions can be drawn from the experience of a few cases only, and of this truth we have no better evidence than is to be drawn from the literature of the medical treatment of diphtheria.

The general estimate of recoveries after tracheotomy, in the diseases under discussion, is very fairly accurate, viz., one in four. The statistics of M. Sanné drawn from the Paris Hospitals for the years 1854 to 1875, extending over 4,663 cases,<sup>1</sup> placed the average rate of recoveries at 1 in 4.18. Showing how many factors alter the value of statistics from year to year, the very next year, viz., 1876, at the Hospital Sainte Eugénie the proportion of recoveries only

<sup>1</sup> Moizard : *Thèse de Paris*. (Quoted by Morell Mackenzie, *Diphtheria*, p. 93.)

attained to 1 in 8·31, and this unfavourable result was attributed to the fact that the operation was extended to cases more and more hopeless in prognosis, and possibly also to the greater malignancy of the disease in that year.

From 1864 to 1876 the statistics of the Hospital for Sick Children in London record 21·6 per cent. of cures.<sup>1</sup> Solis Cohen<sup>2</sup> recorded 110 recoveries out of 166 tracheotomies. These, however, were selected cases. Taking the published statistics of the principal German hospitals for 1882-3-4,<sup>3</sup> we find that of 1,298 tracheotomies there were 414 recoveries. The hospitals in question were the St. Annen Kinderspital, St. Josefs, Leopoldstädter, Kronprinz Rudolf, Carolinen-Kinderspital, of *Vienna*, a total for the years 1882-3-4 of 381 cases tracheotomised, with 196 recoveries; the Kaiser Franz Josef Kinderspital in *Prague*, 120 tracheotomies with 44 recoveries; the St. Ludwig Kinderspital in *Cracow*, 30 tracheotomies with 15 recoveries; the Kinderheil- and Diakonissen-Anstalt of *Stettin*, 38 tracheotomies with 14 recoveries; the Kinderheilanstalt of *Dresden*, 485 cases with 70 recoveries; the Kinderspital of *Basle*, 80 tracheotomies with 30 recoveries; the Kinderspital (Hottingen), at *Zurich*, 58 tracheotomies with 19 recoveries. The Christ's Kinder Krankenhaus, *Frankfurt*, the St. Wladimir-Kinderhospital, *Moscow*, the Elizabeth-Kinderhospital, *St. Petersburg*, the Jenner'sches Kinderspital, *Berne*, in all of which the returns are incomplete, show a total of 106 cases, with 26 recoveries.

KESTNER<sup>4</sup> gives the statistics of the Children's Clinic at Strasburg as follows:—

In 1879.	14 cases tracheotomised;	2 cured;	12 dead.
1880.	15 „ „	5 „	10 „
1881.	41 „ „	7 „	34 „
1882.	35 „ „	1 „	34 „

Thus, of 105 cases operated on, only 15 were cured, while the mortality reached the frightful total of 90. The cases treated without tracheotomy at this clinic fared better, as is seen by the following figures:—

Percentage of fatal cases,

after tracheotomy ... 85·2 males; 86·3 females; total, 85·7.

Percentage of fatal cases,

without tracheotomy ... 45·5 „ 41·1 „ „ 43·0.

<sup>1</sup> Mackenzie: *Diphtheria*, p. 94.

<sup>2</sup> *Croup in its Relation to Tracheotomy*. Philadelphia, 1874.

<sup>3</sup> *Jahrbuch für Kinderheilk*, N. F. Band xx., xxi., xxii., xxiii., xxiv., xxv.

<sup>4</sup> *Statistik*, f. 1879-1882, *Med. Kinderklinik zu Strassburg*, *Jahrbuch f. Kinderheilk*, Bd. xx., xxi.



HAGENBACH<sup>1</sup> gave the results of 130 cases of tracheotomy performed at the Kinderspital in Basle from 1872 to 1881, in which there resulted 42 cures, or 35·3 per cent.

At the Leopoldstädter Kinderspital in Vienna, from 1873 to 1883, 106 tracheotomies were performed for croup. Of these 75 resulted fatally, giving a percentage of recoveries of only 32.<sup>2</sup>

PLENIO<sup>3</sup> gives the following statistics for Königsberg :—

In 1878—79, tracheotomies performed,	16 ;	deaths,	9
„ 1879—80,	„ „ 21 ;	„	8
„ 1880—81,	„ „ 28 ;	„	16
„ 1881—82,	„ „ 58 ;	„	30
„ 1882—83,	„ „ 111 ;	„	47
	<hr/>		<hr/>
	234		110

This gives a high percentage of deaths, but it must be remembered that at this clinic only those cases are admitted in which tracheotomy becomes a necessity, or the operation is likely to be required early, and the cases are drawn from the poorest classes.

At *Zurich*<sup>4</sup> in the clinics of Professors Kronlein and Bose, from 1868 to 1882, 295 cases of diphtheria with laryngeal stenosis were admitted, of which 238 were tracheotomised ; of these, 92 recoveries (39 per cent.) are recorded, 20 per cent. being cured without operative measures. The total of all cures, with or without operation, amounted to 50 per cent.

HENOCH'S<sup>5</sup> statistics at the Hospital de la Charité, for 1882 and 1883, were, of 138 tracheotomies, 16 recoveries only (11½ per cent.). Henoch, however, admits only one contra-indication, viz., the coincidence of very marked symptoms of infection with phenomena of asphyxia.

MAX SPENGLER<sup>6</sup> gives the statistics of the Diakonissen-Anstalt in Dresden, as follows :—From 1868 to 1882, 510 cases of croup and diphtheria were admitted, of which 196 cases called for tracheotomy : of these 70 only were cured, and 126 died, thus giving a percentage mortality of 64·2.

At Darmstadt, from 1873 to 1883,<sup>7</sup> 140 tracheotomies were per-

<sup>1</sup> *Die Diphtheritis Epidemie in Kinderspital in Basel, Jahr. des Kinderspit. in Basel, 1882.*

<sup>2</sup> Unterholzner : *Jahrbuch f. Kinderheilk.*, 1885, Bd. xxii.

<sup>3</sup> *Tracheotomie bei Diphtheritis, Aus. der Chir. Universitäts Klinik zu Königsberg, Arch. f. M. Chir.*, 30 Bd., 4 Heft.

<sup>4</sup> Luning : *Resultate und Technik der Tracheotomie bei Croup und Diphtherie. Correspond. Bl. f. Schweizer Aerzte*, No. 3, 1883.

<sup>5</sup> *Charité Annalen*, x., p. 490.

<sup>6</sup> *Diphther. und Croup, Deutsch. Archiv. f. Klin. Med.*, Band 34, Heft 3.

<sup>7</sup> Birnbaum : *Beitrag zur Statistik der Tracheotomien, Arch. f. Klin. Chir.*, Bd. 31, Heft 2.

formed at the *Krankenhaus*; of these 93, or 66·42 per cent., were fatal.

The total figures of 2,403 cases of tracheotomy collected from Vienna (1882-3-4), Prague (1882-3-4), Cracow (1882-3-4), Stettin (1882-3-4), Dresden (1868-84), Basel (1871-1884), Moscow (1882), Zurich (1868-1884), Strasburg (1879-1882), Königsberg (1878-1882), Berlin (1883), Darmstadt (1873-1883), incomplete as they may be, yet afford a very fair means of estimating the average mortality of this operation in croup. Of these 2,403 cases, only 783 recoveries are noted. This is under the two-fifths usually estimated.

With regard to France, we have already quoted Sanné's statistics for 1854 to 1875.

In 1883 at the Trousseau Hospital,<sup>1</sup> 359 cases were operated on, of which 115 were cured, and 244 were fatal: 32 per cent. cured.

In 1884 the recoveries reached only 26·8 per cent.

In 1885<sup>2</sup> of those tracheotomised the cures were 113, and the deaths 293: 26·8 per cent. cured. Of those not tracheotomised the cures were 69, and the deaths 4.

In 1886, number operated on, 363, the cures were 106, and the deaths 257: 29·23 per cent. cured. Of the numbers not operated on (62), the cures were 54, and the deaths 8.

At the Hôpital des Enfants, during 1886, 355 operations were performed for croup, with 295 deaths and 60 cures; thus giving a total percentage of 16·9 recoveries only.

For the years 1883 to 1886 inclusive the Trousseau Hospital thus gives a percentage of 28·95. This contrasts very favourably with the low figure of 16·9 per cent. of recoveries out of the 355 tracheotomies performed at the Hôpital des Enfants during 1886. The difference between these two sets of statistics for 1886 is inexplicable.

The season of the year at which the operations are performed is not without influence upon the result. Thus Birnbaum<sup>3</sup> found at Darmstadt that the fatalities were greatest in December, February and January, and least in June. Florand<sup>4</sup> found that in—

Jan. and Feb., of 105 cases, 71	{	required	{	47 died; 24 recovered.
		tracheotomy		
March and April 96	„	64	„	41 „ 21 „
May and June 99	„	47	„	38 „ 9 „
July and August 76	„	43	„	21 „ 22 „
Sept. and Oct. 86	„	53	„	38 „ 16 „
Nov. and Dec. 144	„	81	„	61 „ 20 „

<sup>1</sup> Florand: *Rev. mens. des Mal. de l'Enfance*, February, 1884.

<sup>2</sup> Eugène Revilliod: *Rev. mens. des Mal. de l'Enf.*, March, 1886.

<sup>3</sup> *Loc. cit.*

<sup>4</sup> *Rev. mens. des Mal. de l'Enf.*, February, 1884.

Thus the summer season showed distinctly better results than the winter.

UNTERHOLZNER<sup>1</sup> noted the same in Vienna. For the ten years 1873 to 1883 the coldest quarters, *i.e.*, the first and fourth quarters of the year, showed the smallest percentage of recoveries, the summer quarters giving the most favourable results. Many obvious causes contribute to make the prognosis worse during the colder, windy, uncertain and inclement seasons of the year, which scarcely need indication.

With regard to the age of the patient, it is universally admitted that the mortality is greater the younger the child operated on.

SANNÉ<sup>2</sup> estimated that in children operated on at the St Eugénie Hospital, of those—

1—2	years old	...	1	in 7.42	recovered after tracheotomy ;
3—5	" "	...	1	4.35	" " "
6—10	" "	...	1	2.63	" " "
11—15	" "	...	1	2.88	" " "
while at the Hôpital des Enfants					
1—2	years old	...	1	in 10	" " "
3—5	" "	...	1	5.20	" " "
6—10	" "	...	1	1.79	" " "

SOLIS-COHEN<sup>3</sup> remarks that "comparatively few children under two years of age are saved, not many over eight or nine, and adults only as the exception," tracheotomy for diphtheria in the adult being rarely successful, from the fact that when diphtheria has invaded the adult larynx it has already assumed a grave character independently of the laryngeal condition.

UNTERHOLZNER<sup>4</sup> states that in the Leopoldstädter Kinderspital 75.80 per cent. of children from 1 to 4 years old die; 63.89 of those from 4 to 7; and 62.5 per cent. of those from 7 to 13 years of age. There is no doubt that in the earlier years of life the mortality after tracheotomy is appalling. Age, however, forms no contra-indication to the performance of tracheotomy. A successful result has been obtained in a child of only six weeks of age, and the operation is frequently called for in children under one year of age. That the circumstances surrounding the patient should influence the course of the disease, goes without saying. If the operation is performed in

<sup>1</sup> *Jahrbuch für Kinderheilk*, 1885, vol. xxiii.

<sup>2</sup> *Traité de la Diphth.*

<sup>3</sup> Ashurst's *Encyclop. of Surgery*, vol. v., p. 706.

<sup>4</sup> *Loc. cit.*

unsettled, rainy, cold, or windy weather, in gloomy, damp, badly ventilated, or draughty dwellings, especially in the neighbourhood of places already infected, or in over-crowded, poverty-stricken, and unsanitary houses, or in individuals deprived of the luxuries or even necessities of life, the prognosis cannot but be unfavourable. Such patients rarely recover.

At what stage of the disease should the operation be performed ?

In most countries it is usual to perform tracheotomy as soon as it appears evident that signs of asphyxia are imminent,<sup>1</sup> but in France the operation has been frequently done as soon as the nature of the case was obvious. This method yields a more satisfactory result as regards the operation ; but the trachea is often opened unnecessarily, and the total mortality among the patients is probably much greater. Recession of the chest walls, especially in conjunction with suppression of voice, are valuable signs of the amount of obstruction. "If expiration is as laboured as inspiration there is no time to lose."<sup>2</sup> It is better to be too early than too late in doing the operation, and Guersant's maxim is to the point, "The younger the child, the less can we afford to delay the operation." It should always be borne in mind that the object of tracheotomy is to promote aeration of the blood, and not to exert any influence upon the disease itself. "In the majority of cases the patient dies from want of oxygen and exhaustion of the nervous system ; and the object of tracheotomy is to render oxygen accessible to the child ; and it should be remembered that every draught of fresh air assists in the cure."<sup>3</sup> It is true, as Guersant pointed out, that the resolution of pneumonia is facilitated by the free entrance of air into the lungs, and the free oxygenation of the pulmonary air cannot fail to have a more or less remedial effect on the course of the disease, and help to ward off pulmonary complications. There is no excuse for delaying the operation, as soon as the first signs of laryngeal stenosis appear. As Winters remarks, "It is a far weightier responsibility to decide when to operate, than merely to open the windpipe."<sup>4</sup>

Ranke's<sup>5</sup> rule is a very safe one to follow : "As soon as a child becomes hoarse and voiceless, with one or more short lasting dys-

<sup>1</sup> Morell Mackenzie : *Dis. Throat and Nose*, vol. i., p. 191.

<sup>2</sup> Parker : *Tracheotomy*.

<sup>3</sup> J. E. Winters : *Is the Operation of Tracheotomy in Diphtheritic Croup Dangerous? When should the Operation be Performed?* *Trans. New York Acad. of Med.*, vol. i., 1886.

<sup>4</sup> *Loc. cit.*, p. 86.

<sup>5</sup> *Tracheotomie Resultate bei Systematischer Durchgeführter Ventilation*, *Jahrbuch f. Kinderheilk.*, 1886, vol. xxiv.

pneic attacks, and in the intervals of the attacks the breathing has a laryngeal sound, then is tracheotomy indicated." Jacobi remarks<sup>1</sup> there is "no alleged contra-indication to tracheotomy, whether the tender age of the patient, or a complication with either an inflammatory or an infectious disease, must be considered valid. The one strict indication for the performance of tracheotomy is where the diagnosis of pseudo-membranous laryngitis is undoubted. The increasing dyspnœa, cyanosis, and approaching asphyxia, with the certainty that a well-directed and efficient medical treatment has been, and in all probability will be, useless; even under these circumstances, there is no mathematical certainty. The matured experience of a well-informed and thoughtful physician will commit but few errors. If there be the slightest doubt, the operation ought to be preferred to suffocation." Morell Mackenzie<sup>2</sup> knows no contra-indication to the operation, even when the patient is apparently at the point of suffocation, "provided only that the heart's power is still good." The extension of the disease to one of the lungs, or presence of extensive pneumonia, renders the prospects of the operation very gloomy. Ranke,<sup>3</sup> however, thinks that pulmonary inflammation should not contra-indicate the operation, and Henoeh<sup>4</sup> considers that very marked signs of general infection with asphyxia form the only contra-indication. Birnbaum<sup>5</sup> states that at Darmstadt, tracheotomy was avoided in all cases in which the disease had invaded the finer bronchi. Lindner,<sup>6</sup> of Mecklenberg, relies on the recession of the chest wall over the cardiac region (Herzgrube) as the earliest sign indicating necessity for operation. He states that he has found all children die who present this sign and whose parents refuse tracheotomy. In Königsberg<sup>7</sup> the operation is done as soon as the child commences to use the auxiliary muscles of respiration. It must not be forgotten, however, as Winters points out in his valuable paper, that though recession of the soft parts of the chest wall with every inspiration is a valuable sign of the amount of interference with that act, it does not necessarily indicate the presence of false membrane in the larynx, the symptoms may be due to spasm; but if, along with suppression of the voice there is laboured, prolonged, and audible expiration, nothing but mechanical obstruction can produce these symp-

<sup>1</sup> Pepper's *System of Medicine*, vol. iii.

<sup>2</sup> *Loc. cit.*

<sup>3</sup> *Loc. cit.*

<sup>4</sup> *Charité Annalen*, x., 1885, p. 490.

<sup>5</sup> *Loc. cit.*

<sup>6</sup> *Loc. cit.*

<sup>7</sup> Plenio, *loc. cit.*



toms. Where they remain *without intermission*, they cannot be due to spasm, and too clearly point out that the larynx has become invaded.

Undoubtedly too many patients are allowed to die from indecision on the part of the operator. It should be a golden rule to *operate early, slowly, and carefully*, and not to halt between two opinions until the child has passed from a comparatively comfortable stage "in extremis." There is probably no operation in which indecision is more fatal. This indecision is partly due to the failure of the operator to realize the right moment for action, and partly to fancied dangers as to the operation itself. Trousseau's maxim, that a badly performed operation, with skilful after treatment, will lead to a satisfactory result in many a case in which an operation, skilfully performed as possible, left to careless after treatment, would have been followed by fatality, should be always borne in mind. The country practitioner should always be able to perform tracheotomy, and should have the necessary instruments always in his possession. The prognosis of his case may become absolutely hopeless while he is occupied in sending miles for the skilled surgeon, and he should have sufficient knowledge of anatomy and surgery to be able to act promptly in an emergency. R. DE LA S.

(*To be continued*).

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## INSTRUMENTS AND THERAPEUTICS.

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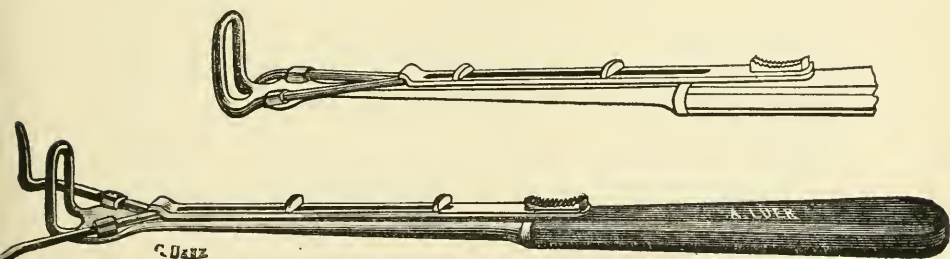
### LUC'S Pharyngeal Dilator for Inspection of the Naso-Pharynx] (Modification of Voltolini's Palate Hook.)

THIS modification of Voltolini's palate hook consists in the adjunction of two moveable branches, by means of a ring that may be pushed along the horizontal rod of the hook. When the instrument is closed, the branches are folded against the extremity of the hook. In this position the instrument is to be introduced behind the uvula, in order to draw it as far forwards as possible. The ring is then pushed in the contrary direction, and at the same time the branches separating from one another open widely and leave a triangular orifice, limited by the velum which is pulled forwards, and the separated palatine pillars on each side. One has simply then to apply properly a large laryngeal mirror under the dilator to be able to inspect any detail of the upper pharyngeal cavity.

This instrument may be applied off-hand to *tolerant* patients. Hyper-sensitive patients must have the pharyngeal mucous membrane, and especially the upper surface of the velum, painted with a strong solution ( $\frac{1}{2}$ — $\frac{1}{4}$ ) of chlorhydrate of cocaine in order to give tolerance to the contact of the instrument. Luc's chief object in modifying Voltolini's hook was to prevent the bringing together, spasmodically or mechanically, of the posterior pillars of the velum. This action constitutes the chief drawback of the latter instrument, since it narrows the aperture transversely, while lengthening it forwards. Thanks to Luc's improvement the pharyngeal orifice becomes enlarged and lengthened at the same time.

The instrument, such as we have described, has proved of great help to the author—

1. For the inspection of the pharyngeal vault and the local treatment of the diseases of Luschka's *bursa*.
2. For examinations for adenoid pharyngeal vegetations, and in order to note their precise relations, and especially to ascertain whether operations for the removal of these growths have been completely successful.



**LENZMANN** (Dinsberg).—A New Battery for Galvano-Caustic and Illuminating Purposes, constructed by Dr. Ernst Landmann, in Dinsberg, with Remarks on the Use of the Galvano-Cautery Wire. *Deutsche Med. Zeit.* No. 7. 1887.

THIS is a new zinc and carbon battery, with some improvements, by which it is possible to direct the strength of the stream easily, and to enable the operator to vary the strength of the current during the application of the wire. MICHAEL (Hamburg).

**BARATOUX**.—Illumination in Laryngoscopy and Otoscopy. *La Pratique Médicale.* No. 5. 1887.

As much as possible, solar light should be used for illumination in laryngoscopy and posterior rhinoscopy, and diffused light for otoscop

and anterior rhinoscopy. In default of natural light, gas or petroleum lamps should be employed. The author speaks favourably of the Welsbach light.

**LANDGRAF** (Berlin).—**On Catheterism of the Greater Air Passages.**

*Berl. Klin. Woch.* No. 6. 1887.

A PATIENT, fifty-two years old, had all the symptoms of a broncho-stenosis of the left side. It was not possible to determine whether it was due to syphilitic stenosis, or aneurysmal compression. After using cocaine to the larynx and trachea, it became possible to introduce a catheter of 32 ccm. into the trachea. Attacks of suffocation became rarer, the patient was relieved for a time, but died subsequently, in a suffocative attack. Necropsy revealed an aortic aneurysm.

MICHAEL.

**MACKENZIE, JOHN N.** (Baltimore).—**Treatment of Catarrhal Affections by the Internal Administration of Hydrogen Dioxide.**

*Practice, Richmond, Va., December, 1886.*

THE success attending the topical use of this drug by American dentists in suppurative affections of the teeth and gums, led to its employment as a local wash or spray in catarrhal inflammation of the middle ear, and naso-pharyngeal cavities. Mackenzie calls attention to the fact that the *internal* administration of the dioxide, in a fair proportion of cases, not only assists the secretion, but has done so after many well-known and orthodox plans of treatment had been resorted to without success. A 4 per cent. solution of the dioxide, given in doses of two drachms to half-an-ounce four to six times daily, is the strength usually employed by him. It is better to have the drug prepared in small quantities, although the 4 per cent. solution will last for a long time if kept in a cool place. The internal administration of the drug may be combined with its topical use in form of spray (6 per cent.). The mucous membrane of the air-passages is in some persons, however, exquisitely sensitive to its action, and cannot tolerate it, even in weak dilutions. A remarkable effect of the internal administration is the relief given to the gastric derangements so frequently associated with catarrhal affections of the upper air-passages. Even in cases in which there has been little good effect in the direction of the nasal and throat symptoms, the stomachic phenomena have disappeared, and several patients report themselves cured of "dyspepsia," since using it. One patient finds great relief from its use in coryza, in which affection it mitigates the severity of the symptoms, and apparently cuts short the duration of the cold. The remedy is not a panacea, and in some cases fails to exert any

beneficial effect, but within proper limits may be regarded as a valuable adjunct in the constitutional treatment of catarrhal affections.

**Various Methods of Disguising the Odour of Iodoform.**

1. Add to iodoform either—

*a*, Some drops of essence of bitter almonds ;

*b*, A little tannin ;

*c*, A little balsam of Peru.

2. Make an emulsion of iodoform, with equal parts of oil of sweet almonds.

Iodoform, 30 grammes.

Charcoal powder, 60 grammes.

Sulphate of quinine, 10 grammes.

Essence of mint, 1 gramme.

*La Pratique Médicale.*

[Mixing with equal parts of freshly ground coffee is also effective.]

**Anti-Strumous Resolvent Lotion** (Descroizittes).

R Chloride of sodium,  $\overline{3}10$ .

Sulphate of magnesia,  $\overline{3}\frac{3}{4}$ .

Tincture of iodine,  $\overline{3}\frac{1}{4}$ .

Distilled water,  $\overline{3}37\frac{1}{2}$ .

Compressors soaked in this solution are applied to strumous enlargements. *L'Union Médicale* (*Canad. Pract.*, February, 1887).

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## DIPHTHERIA.

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**BARBOT.**—Treatment of Diphtheria. *Gaz. des Hôpitaux*, January 20, 1887.

IN this disease the author has effected forty-eight cures by the Renou method (antiseptic fumigations, roast meat diet, and no cauterizing of the throat).

JOAL (Mont Dore).

**KLEIN** (Liebenthal).—Corrosive Sublimate as a Remedy for Diphtheria. *Deutsche Medicinal Zeitg.*, 1887. No. 17.

THE author has often used this medicament, but without the very good results claimed by Dr. Welcker.

MICHAEL.

**KORBSEN** (Kappitz).—**Corrosive Sublimate as a Remedy for Diphtheria.** *Deutsche Medicinal Zeitg.*, 1887. No. 17.

THE author has often made use of sublimate, but with indifferent results, and recommends hydrarg. cyanate. MICHAEL.

**MASSEI** (Neapel).—**Corrosive Sublimate as a Remedy for Diphtheria.** *Deutsche Medicinal Zeitg.*, 1887. No. 17.

MASSEI claims priority for the introduction of this remedy, corrosive sublimate having been already used in 1875 by him for diphtheria with good results. MICHAEL.

**ROTHER** (Altenburg).—**Corrosive Sublimate as a Remedy for Diphtheria.** *Deutsche Medicinal Zeitg.*, 1887. No. 17.

THE author used this application some years ago, but now relies more upon hydrarg. cyanate. MICHAEL.

**WELCKER** (Sprendlingen).—**Corrosive Sublimate in Diphtheria.** *Deutsche Med. Zeit.* No. 6. 1887.

THE author has obtained good results from the use of this drug.

MICHAEL.

**WÖLTERING** (Münster).—**Pilocarpin Subcutaneously, an Excellent Remedy for the Throat.** *Monats. f. Ohrenh.* No. 7. 1886.

A COMMUNICATION of three cases of diphtheria and croup treated with subcutaneous injections of pilocarpin. Two cases died. (Truly "ein vorzügliches Halsmittel"!) MICHAEL.

**CHEYNE, W. WATSON.**—**On Early Tracheotomy in Diphtheria.** *Brit. Med. Jour.*, March 5, 1887.

THE arguments used in this valuable article are based on the, as yet, hypothetical pathology of the disease under discussion. But *naturam morborum ostendunt curationes*; and the author's treatment appears to have been eminently successful. Assuming, from Loeffler's researches, that the disease is due to a micro-organism, probably a bacillus, the latter is supposed to grow in the superficial part of the mucous membrane and produce the patch. The bacilli apparently produce ptomaines, which are absorbed into the circulation and give rise to the constitutional disturbance. Thus the disease remains from first to last a local one. Now if the bacilli can be prevented from spreading, the membrane will be arrested and the formation of ptomaines prevented. The author, therefore, treats the local throat affection with antiseptics, and with an amount of success that tends to support the views above expressed. He gives a minute account of the method pursued, and then points out how the same



principles of treatment may be effected when the morbid process has extended to the larynx and windpipe. And for this purpose early tracheotomy is advocated—as soon, in fact, as it is certain that the larynx is affected—chiefly with the view of preventing the spread of the membrane downwards. In adults it is more especially important not to wait for symptoms of obstruction, seeing that these may be absent although the membrane have reached the bronchi. In order to carry these ideas into effect, the trachea must be opened more freely than usual, with the primary object of inspecting the interior of the trachea. If the trachea is healthy it will present a bright red appearance; if membrane be present it will have a dull grey colour. When no membrane has been formed, either a canula is inserted into the lower angle of the wound and the trachea filled up above with strips of thin rag soaked in a watery solution of bichloride of mercury (1 in 2,000), the process being repeated every two hours; or, the trachea is kept open with Golding Bird's dilator, and the surface brushed from time to time with a weak solution of the perchloride. There are contending advantages in each method. If the membrane has spread to the trachea, it is pulled off with dissecting forceps, the resulting raw surface, and especially the spreading edge, being touched with the 1 in 500 bichloride solution. The author concludes by pointing out that the object of the paper is not to recommend the application of any particular antiseptic substance in this disease, but to raise the question of the indications for performing tracheotomy in diphtheria. He believes that many more lives will be saved by opening the trachea early than by waiting till symptoms of obstruction have become manifest. The probable advantages more than counterbalance, he thinks, the possible dangers.

GREVILLE MACDONALD.

**POTAIN.**—*Scarlatina or Diphtheria?* *Semaine Médicale*, January 19, 1887.

THE question arose at the Hôpital de la Charité in reference to a boy of fifteen, whose symptoms were sufficiently ambiguous to render it doubtful whether the disease was diphtheria with a scarlatiniform rash, or scarlatina with modified characteristics. After a detailed study of all the symptoms of the two affections, and comparing them with a view to differential diagnosis, the Professor concluded in favour of scarlatina, where the predominant sign was the angina.

JOAL.

## NOSE.

**HARDAWAY, W. A.** (St. Louis).—**Inflammation of the Hair Follicles within the Nares.** *Journal of Cutaneous and Venereal Diseases.* December, 1886.

DEALS with inflammation of the vibrissæ—folliculitis barbæ. The association of the disease with broken-down health is insisted upon. The author commences with sulphide of calcium in  $\frac{1}{10}$  gr. doses every three hours for a few days. This is followed by cod-liver oil in the annexed emulsion:—

R	Ol. morrh.	...	...	℥iv.
	Pancreatin. sacch.	...	...	℥i.
	Pulv. acacia	...	...	q.s.
	Glycerit. hypophosphit.,			
	Syr. calcii lactophosphat.,			
	Aquæ	...	...	āā ℥iv.
	Ol. gaulther.	...	...	gtt. xxx.
Ft.	emulsio.			℥ss. t.i.d., after meals.

In the local management of the acute stages, he applies freely, inside and outside of the nose, a mixture of glycerine and Squibb's glycerole of the sub-acetate of lead. After the pain subsides, Van Harlingen's ointment<sup>1</sup> for eczema is used in the same manner. Frequent relapses of this affection may call for destruction of the hair follicles by means of electrolysis.

J. N. MACKENZIE.

**VOLTOLINI** (Breslau).—**Remarks on Parasites in the Ear and the Nose of Man and Higher Mammalia.** *Monatsschr. für Ohrenheilk.,* &c., 1886, Nos. 8 and 9.

A REPRODUCTION of cases published some years ago by Dr. Joseph, with historical remarks.

MICHAEL.

**ZIEM** (Danzig).—**On Neuralgic and Nervous Affections proceeding from Diseases of the Nose and Throat.** *Monatsschr. für Ohrenheilk.,* 1886, Nos. 8 and 9.

AN essay on the literature of the different affections described as arising from diseases of the nose and pharynx, with some theoretical explanations and original observations.

MICHAEL.

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<sup>1</sup> The composition of the ointment is as follows:—

R	Glycerol. plumbi subacetat. (Squibb)	℥ss.
	Glycerin.	...
	Ung. aq. rosin.	...
	Ceræ alba,	...
		q.s.

Ft. ung.

**BRESGEN** (Frankfort).—Origin, Importance, and Treatment of Callous Thickening of the Septum Narium. *Wien. Med. Presse*, Nos. 7 and 8, 1887.

A GOOD review. Chromic acid is extolled by the author for these conditions.

MICHAEL.

**FRONTIS, DAVID B.** (Wadesborough, N.C.)—Two Cases of Abscess of the Antrum simulating Chronic Nasal Catarrh. *North Carolina Medical Journal*, January, 1887.

IN both cases, which are related at length, nasal cough was the most prominent and interesting symptom; and, according to the author, unquestionably reflex in nature. Frontis attributes the cough to reflex irritation of the sensitive area located by the reviewer, lays stress on the difference in percussion resonance over the antrum on both sides as a means of diagnosis, and insists upon the necessity of making a free opening in the diseased cavity and securing thorough drainage.

J. N. MACKENZIE.

**HUBBELL, A. A.** (Buffalo).—Congenital Occlusion of the Posterior Nares. *Buffalo Med. Journal*, December, 1886.

RELATES an interesting case, and gives an excellent *résumé* of the literature of the deformity.

J. N. MACKENZIE.

**RICHEY, S. O.** (Washington).—Prophylaxis in Rhinitis Symptomatica. *Chicago Med. Journal and Examiner*, December, 1886.

RICHEY believes with the reviewer that the phenomena of this disorder are the peripheral expression of a more central disturbance, "the impairment of the balance of circulation in the cervical plexus," and considers the initial cause to be insufficient protection of the body, and especially the spinal region, from decided and quickly repeated alterations of temperature. A sufferer himself from the disease, he has found most marked relief from wearing flannel next to the skin in winter, which in summer is replaced by the open work French netted goods. The suggestion is offered, that with the dissipation of the nasal and throat symptoms, the affection may indicate its presence in another way, as, for example, in *petit mal*.

J. N. MACKENZIE.

**McBRIDE, P.** (Edinburgh).—Lecture on Nasal and Naso-Pharyngeal Reflex Neuroses. *Brit. Med. Journal*, January 29, 1887.

A REVIEW of the various views held as to these conditions. The author concludes with a well-timed reference to the recent paper of

Bœcker's (see this Journal, Jan., 1887), which he describes "as a very useful antidote to those who are inclined to be too active in attacking by surgical operations the noses of those who suffer from asthma and other neuroses."

**COHEN, S. S.** (Philadelphia).—**A Case of Hysterical Sneezing apparently Cured by Intra-Nasal Applications of the Continuous Battery Current.** *New York Med. Journal*, January 29, 1887.

IN a neuro-mimetic, hysterical girl, subject as she said to paroxysms of violent sneezing, and who came to be treated for "hay fever" by the electric cautery, Cohen found the nasal passages apparently free from disease, but on the left side of the septum high up, pressure with the probe gave rise to exquisite pain, and a sensation as if she were going to have an attack. After trying a palliative course of treatment with cocaine, internal medication of various kinds was instituted without success. The paroxysms were finally kept under control for two months by the application of belladonna and cacao-butter in various strengths to the sensitive spot on the septum. Six weeks after cessation of treatment she had a recurrence, and daily applications of the constant current were decided upon, the positive electrode being placed on the sensitive area, the negative upon an indifferent point on the cheek. After two weeks, the patient professed herself well. Cohen is uncertain as to whether the cure was due to the current, or to the mental impression which the electricity created.

J. N. MACKENZIE.

## TONSILS, PHARYNX, &c.

**MORGAN, E. C.**—**The Question of Hæmorrhage following Uvulotomy.** *A Reprint from the New York Med. Journal*, 1886.

THE author has produced an elaborate historical essay, of quite a unique character. The opinions of various authors as to uvulotomy are here collected and expressed, from 400 B.C. to 1886 A.D. The author addressed inquiries to all prominent laryngologists throughout the world as to cases of uvular hæmorrhage met with by them in their practice. The replies to questions asked enabled Dr. Morgan to formulate the following conclusions:—

1. A fatal or uncontrollable hæmorrhage has, in one instance, followed a uvulotomy.
2. A persistent, obstinate, or alarming hæmorrhage is only encountered in the rarest instances.

3. A moderate bleeding, ceasing spontaneously or by the use of mild styptics, occasionally happens.

4. The loss of a few drops of blood at the time of operating, followed by slight oozing, is of common occurrence.

5. The most reliable surgical methods for controlling uvular hæmorrhage are the ligature, compression by the clamp or forceps, or the use of the galvano or actual cautery.

6. The most reliable styptics are, in the order named, solid silver nitrate, or iron persulphate, directly applied to the bleeding stump, and solutions of gallo-tannic acid, or alum. To these may be added the local use of ice, ice-water, and vinegar.

7. The most reliable systemic means are opium, lead acetate, sulphuric acid, and ergot.

The author has devised an ingenious clip, to seize the bleeding uvula and arrest hæmorrhage.

**Accidents during Tonsillotomy.** *Brit. Med. Journal*, March 12, 1887.

DR. SCHULER (of Rorschach) in excising the tonsils with Mathieu's tonsillotome met with a rather serious accident. The middle (cutting) ring of the instrument suddenly gave way, and a piece about one centimètre long fell out, but was promptly picked out of the patient's mouth. In a similar accident, which recently occurred in the practice of a colleague of Dr. Schuler, the patient swallowed the part of the knife which had become detached. A third case of the kind was recently published in the *Union Médicale*, No. 48, 1886, by Dr. Edmond Barré. The circular knife was broken into two pieces, one of which was extracted from the pharynx, while the other, two and a half centimètres long, was swallowed by the patient, and expelled from the anus three days later.

**RENDLEMAN, J. J.** (Makuda, Illinois).—**Dysphagia Clericorum.** *Southern Practitioner*.

NOTHING new.

J. N. MACKENZIE.

**GRADLE, H.** (St. Louis).—**Diseases of the Vault of the Pharynx.** *Chicago Med. Jour. and Examiner*, January, 1887.

NOTHING new.

J. N. MACKENZIE.

**HASLUND** (Copenhagen).—**Two more Cases of Syphilis arising from Infection through the Pharynx.** *Hospitalstidende*, March 9, 1887.

THE author, who has formerly described four cases of chancres of the pharynx, believes that they are more common than generally



thought. In the first patient, a girl aged eleven years, there was a chancre with distinct induration of the size of a halfpenny-piece, extending from the left side of the uvula down to the pillars of the fauces and the left tonsil. In the other patient, a single woman aged twenty-seven years, the ulceration was healed, leaving an unusually hard induration of the right side of the whole space between the pillars, extending backwards to the side wall of the pharynx. In both cases there was a hard swelling of the corresponding glands about the angle of the jaw, and in both patients secondary syphilitic phenomena were present. In neither case could the mode of infection be traced or even suspected. HOLGER MYGIND.

**VIARD.**—**Contribution to the Study of Tertiary Syphilis of the Throat.** *Thèse, Paris, 1887.*

TERTIARY syphilis has a special predilection for the back of the throat, and is manifested in that situation by tuberculo-ulcerative syphilides, or gummata. These lesions occur generally about the fourth or fifth year of the diathesis, at the period when the malady becomes constitutional. Hereditary syphilis is frequently localized in the back of the throat, and may, under these circumstances, lead to difficulty in diagnosing from scrofulo-tuberculosis. In cases of doubt, the author recalls Ricord's dictum: "Scrofula possible, syphilis probable." The exciting causes are, the gravity of the diathesis, alcoholism, privation, and absence or insufficiency of treatment. JOAL.

**CHABROL.**—"Ludwig's Angina." *Thèse, Paris, 1887.*

THE author considers this complaint to be an affection of the sub-hyoid region, distinct from sub-maxillary adeno-phlegmonous conditions. The disease is characterized by induration of the sub-maxillary region, and of the floor of the mouth, accompanied with falling back of the tongue, and troubles of respiration and deglutition, proceeding rapidly to gangrene, and accompanied with typhoid symptoms. It is probably due to a micro-organism, the nature of which is yet undetermined, and the disease appears to be, in some cases, contagious. JOAL.

**ROSS (Montreal).**—**Cancer of Œsophagus.** *Canadian Practitioner, February, 1887.*

STRICTURE with increasing difficulty in deglutition during life. Sudden death. At the autopsy, epithelioma of œsophagus forming

ulcerated surface 5 inches long; calibre of gut not much narrowed. Death from bursting of a cerebral abscess.

**OGSTON, Prof. Alex.**—On the Diagnosis of Stricture of the Œsophagus. *Manchester Med. Chron.*, January, 1887.

STRICTURE at the lower end is usually cancerous, and occurs after middle life, and is the easiest to diagnose. Peri-œsophageal irritations, suppuration and abscess are common in such patients, and the passage of a probang may perforate the wall, and at all events usually aggravates the condition and determines the formation of abscess. A small probang may also easily pass the stricture without detecting it. Stricture at the upper end is usually found in the young, or under middle life, and is the most difficult of diagnosis. Prof. Ogston refers to Hamburger's statement that on ausculting the œsophagus the ear will recognize a sound produced at the seat of stricture by the passage of swallowed food, solid or liquid, for at this point the "egg-shaped form" of the ingesta is broken up and the change can be recognized. Ogston says that at this point is heard a detention of the normal sound—which is a rushing or gurgling of the food in the gullet—and followed, if the food be fluid, by a squirting sound. But this is not always heard, for in the cases especially where the stricture is narrow and opposite the larynx, the churning produced by the pharynx, in efforts to force on the food, drowns all other sounds. The rapidity of the passage of the food along the gullet is a very valuable sign. A healthy person requires four seconds for passage of food from the mouth to the stomach. The rising of the pomum Adami tells that it has passed the pharynx into the œsophagus, and placing the ear three inches below the angle of the left scapula, a distinct amphoric gurgle or rushing sound tells that food has entered the stomach. With watch in one hand, finger on the pomum Adami, and directing the patient to hold fluid in the mouth till told to swallow, the time of entrance into the stomach can easily be calculated. In case of stricture, the food takes fourteen or sixteen seconds instead of four to traverse the œsophagus. Though the sign may mislead, or be inapplicable occasionally, Ogston finds it very useful and reliable in most cases.

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## LARYNX.

**PAPAVANT** (Frankfort).—**The Manner in which the Larynx is Closed during Swallowing.** *Virchow's Archiv., Band 104, Heft 3.*

THE larynx is raised to the hyoid bone, which is itself a little elevated. Compression of the fatty tissues from above downwards results, so that the epiglottis is thus pressed downwards to the upper laryngeal space. The ary-epiglottic folds approach towards the laryngeal portion of the epiglottis; at the same time there is straightening of the upper laryngeal space by compression of the true and false ligaments and the arytenoidei, and elevation of the hyoid bone and larynx towards the tongue, causing the epiglottis to lie in the vallecula. The epiglottis is further pushed over the laryngeal aperture by pressure of the fat at the lowest part of the tongue.

MICHAEL.

**PORTER, WM.** (St. Louis).—**Erysipelas of the Upper Air Passages.** *New England Medical Monthly, November, 1886.*

AFTER reference to some well-known facts in regard to the affection under consideration, Porter gives a brief report of a case of erysipelas of the pharyngo-laryngeal membrane, in which tracheotomy was resorted to in order to save life from laryngeal œdema. The patient died on the day following the operation from pulmonary œdema.

J. N. MACKENZIE.

**BUCKMASTER, A. H.** (Brooklyn).—**A Case of Submucous Laryngitis Treated with Hot Water.** *New York Medical Journal, January 22, 1887.*

CALLED suddenly to perform tracheotomy in a case of acute laryngitis with œdema, extreme dyspnœa, cyanosis, and rapid, feeble pulse, Buckmaster determined to try hot water before resorting to operation. A rubber blanket was quickly thrown over the bed, and the patient placed so that her head was lower than her shoulders. A large supply of hot water, at about 120° F., was thrown against the œdematous tissues with a Davidson syringe. The head was turned on its side, so that the water could return and be carried by the sheet into a pail. At first the procedure caused the patient to attempt to swallow; but this was quickly overcome, and at the end of half an hour the symptoms had disappeared.

Buckmaster is unable to find any recorded instance of the use of

hot water in laryngeal cedema. A *résumé* of the observations and experiments of Emmet and Milne Murray with hot water in the blood-vessels is appended to the author's instructive case.

J. N. MACKENZIE.

**CADET de GASSICOURT.**—A Case of General Emphysema Secondary to a Stridulous Laryngitis. *Revue des Maladies de l'Enfance*, February, 1887.

TUBERCULOSIS and whooping-cough appear to be the ordinary precursors of general emphysema; and stridulous laryngitis has not hitherto been quoted as a cause. The author, therefore, feels justified in publishing a case of false croup in a girl of nine years which resulted in emphysema of the neck, in which, with the upper two-thirds of the thorax, it remained localized. It did not extend to the cheeks or temples, and the abdomen, which is most frequently affected, also escaped. No serious consequence arose from the gaseous infiltration.

JOAL.

**ROSENBACH.**—A Case of Localized Laryngitis, and Tracheitis Crouposa in an Adult. *Wiener Med. Presse*, Nos. 4, 5, 1887.

A PATIENT of twenty-four had shivering, rigors, high fever, cough, and tracheal stridor. Membranes were seen, laryngoscopically, in the larynx and trachea. Ecchymoses occurred on the free parts of the mucous membrane. The sputum was blood-stained. Gargles of corrosive sublimate and salicylate of sodium internally were given. The next day casts of false membrane were expectorated. The patient was cured on the seventeenth day. This case, in which all false membranes were spontaneously ejected, proves that it is better to treat such cases expectantly than by local energetic measures, which, by injury to the mucous membrane, may succeed in aggravating the condition.

MICHAEL (Hamburg).

**MAJOR, G. W.** (Montreal).—Prolapse of the Laryngeal Ventricles. *New York Med. Journal*, January 1, 1887.

REFERS to the cases of Moxon, M. Mackenzie, Lefferts, Massei, Waldenburg, Gruber, Cohen, Elsberg, and J. N. Mackenzie, and relates cases of his own. Major insists on the necessity of discriminating between prolapse and eversion. Prolapse may exist without eversion, while eversion cannot occur without prolapse having been a factor for some period, however brief, in its development. In the five cases related by the author (three of prolapse, two of true eversion), three examples occurred in individuals of syphilitic habit.

J. N. MACKENZIE.

**CARPENTER, G. A.**—Aphonia due to Subglottic Growth (? Congenital); Operation; Cure. *Lancet*, March 12, 1887.

THE only point of interest in the case is the possibility of its congenital origin. Mackenzie's tube-forceps were employed.

**SCHROETTER.**—The Dilatation of Stenoses of the Larynx. *Annal. des Mal. de l'Oreille, du Larynx, &c.*, January, 1887.

THIS is the report of a clinical lecture delivered at Vienna during November, 1886, in which Prof. Schroetter described the instruments used by him, and already well known, and the methods and indications for the performance of dilatation. JOAL.

**GAREL, J.**—Vocal Gymnastics in the Treatment of the Undeveloped Voice, and Hysterical Aphonia. *Provence Med.*, December, 1886.

THE author indicates the methods of treatment advised by Bruns, Edouard Fournié, and Michel of Cologne, and cites three cases in which he effected a cure of patients with voices not having "broken," in one hour, one day, three days, respectively, by using Fournié's exercises.

For the treatment of hysterical aphonia, Garel finds intra- or extra-laryngeal faradism sometimes impossible, and employs then the method adopted by Michel. Placing the large laryngeal mirror in the patient's throat, he seeks to excite vomiting, and makes the patient exaggerate the sound produced in retching. Massage of the larynx, as recommended by Oliver of Boston, also gives good results. Garel further relates the cases of three young women, suffering from hysterical aphonia, cured by vocal gymnastics according to Fournié's process. JOAL.

**LUC, Dr.**—Paresis of the Dilators of the Glottis a Means of Diagnosing the Onset of Tabes Dorsalis. *France Médicale*, February, 1887.

A PATIENT sought relief for difficulty in breathing. He suffered from dyspnœa, and his breathing became stridulous on walking or with other muscular effort. The cords were moderately patent during expiration, and instead of opening wide during inspiration they approximated, leaving only a linear space between them, and an appreciable interval between the arytenoids. Is this spasm of the constrictors or paresis of the dilators? The author believes it to be a paralysis of the crico-arytenoidei postici. Evidence of lesions in the nerve-centres was then discovered, such as startings in the legs. The patient complained of sensations like rapid electric shocks.



Sensation was much altered and the knee reflex diminished on the right side. Dr. Luc concluded that it was an incipient case of *tabes dorsalis*.  
JOAL.

**DUGARDIN.**—Note on a Case of Compression of the Recurrents by an Organic Stricture of the Œsophagus. *Ann. Mal. de l'Or., Larynx, &c., January, 1887.*

THIS is the history of a patient afflicted with an œsophageal tumour, and in whom the right vocal cord was at first very congested, and fixed in the phonatory position; the left vocal cord then became less mobile, and the left recurrent became affected. The patient had subsequently attacks of suffocation (imputed to spasm of the adductors), and finally succumbed to cachexia. An autopsy not having been made, the author does not know whether the condition was produced in the left cord by extension of the tumour to that side, so as to enclose the left recurrent, or by ganglionic compression, or whether it was produced reflexly.  
JOAL.

**SCHILLING** (Spremberg).—Hysterical Aphonia lasting Two Years. *Deutsche Med. Zeitung, No. 8, 1887.*

A GIRL of twenty-eight became aphonic through catching cold. The condition was cured after treatment by faradism.

MICHAEL (Hamburg).

**MAJOR** (Montreal).—Cases exhibited at the Medico-Chirurgical Society of Montreal. (From Dr. Major's Clinic.) *Canadian Practitioner, February, 1887.*

1. *Complete paralysis of the right vocal cord*, arising from pressure on the right recurrent by a fibroid. The patient had also signs of lead poisoning (blue line on gums and colic), which had nothing to do with the laryngeal condition. The right vocal cord was completely immobile, resting midway between full inspiration and phonation.

2. *Early laryngeal œdema (tuberculosis)*. No recognisable pulmonary infection. First œdema occurred of left arytenoid, then of right, then of epiglottis, and finally, pulmonary signs. Local improvement followed under lactic acid treatment.

3. *Laryngeal papillomata (three cases)*.

**BRESGEN** (Frankfort).—Spasm of the Glottis, caused by Aortic Aneurism. *Berlin. Klin. Woch., No. 8, 1887.*

A PATIENT who suffered from attacks of laryngeal spasm and dyspnœa died suddenly with hæmorrhage. An aneurism was discovered at

the necropsy, but the relation to the recurrent and vagus nerves could not be traced.

MICHAEL.

**WALFORD, W. G.**—**Functional Aphonia in a Boy.** *Brit. Med. Jour., March, 1887.*

A BOY, not quite eleven years old, afflicted with colic, became unable to utter a sound. Next day, with disappearance of the colic, the voice returned, but absolute aphonia came on again, and persisted for three months, when the voice suddenly returned. Patient was of nervous temperament, and had enuresis.

**MASSEI, Prof. F.**—**Gleanings.** *Archivii, &c., Anno. VII., Fasc. 1.,* UNDER this title the author collects in a concise manner the following clinical notes, as records of daily practice from his case-book :—

(1) The resin and essential oil of turpentine are rightly included in the pharmacology of diphtheria; the former is applied by pencilling and atomizing, the latter by continuous inhalation, and also internally. He regrets that although he suggested the resin in 1875, he has never been accredited with it. Nevertheless, he recognizes greater claims in those who have used it extensively.

(2) In a note published in *Grazzi's Journal*, in 1883, the author justified the employment of the continued current in goitre, without previous use of the aspirator. Latterly, he has confirmed its efficacy in a number of cases, as well as the uselessness of other agents, the risks of which sometimes give considerable anxiety. In three cases of which he relates the history, and especially in two, where thyroidectomy had been proposed, the results were not satisfactory. The method is not dependent on an accurate diagnosis, always difficult enough, for there can be no harm in trying it.

(3) In deviations of the nasal septum he has obtained excellent results from measures less severe than the compression and straightening treatment of American practitioners, by using either digital pressure (which the patient may practise himself several times a day), or properly applying tampons of cotton-wool, or by employing compressed air with Waldenburg's apparatus. With the last treatment he was enabled in a youth to straighten a deviation to the left of the septum so marked that it occluded the naris, and twisted the point of the nose.

(4) An accident of tonsillotomy manifested itself two hours after the operation, when the patient began to spit blood. A vessel on the cut surface was seized and twisted with the hæmostatic forceps.

The patient then vomited about three hand-basinfuls of blood. It was attributed to the fact that the patient had been swallowing for two hours the blood flowing from the cut artery.

Another accident was experienced in a young woman operated on for bilateral tonsillotomy. Ten days after a blackish projection of the right tonsil was noticed. Believing it to be an inflammatory swelling he reapplied the tonsillotome, and removed a piece of necrosed tissue. In a few days the wound had healed.

(5) The author believes much that has been said concerning the efficacy of lactic acid, given internally for laryngeal tuberculosis, is exaggeration. He can, however, allow that it possesses real merit in chronic hyperplastic laryngitis. He has never given more than 50 per cent. for a dose.

(6) It is said that a laryngeal paralysis may be diagnosed even without the mirror, by feeling for vibration in the two halves of the larynx, the paralysed side being distinguished by absence of vibration. The author, from various cases of unilateral paralysis of the adductors, is convinced that the vibrations were preserved on both thyroid plates. When, however, he has examined cases of unilateral thickening of the tissues, he has found augmentation of the vibrations on the diseased side.

(7) He states certain indications for catheterization of the larynx in non-idiopathic spasm of the glottis: if the latter arises during the destruction of papillomata, or while practising gradual dilatation in organic stenosis of a different nature; if it arises during tracheotomy, or before the instruments for the operation are ready. One of his patients with papillomata owes his life to Schrötter's catheter.

MASSEI.

**SCHECH** (Munich).—**Contribution to the Pathology of Syphilis of the Lung, Trachea, and Bronchi.** *Internationale Klinische Rundschau*, No. 5, 1887.

A LADY of sixty (infected many years before), three years before this date developed cough with bloody expectoration, later on, stridor, nocturnal sweats, and fever. Laryngoscopically two red tumours were seen near the bifurcation of the trachea. Moist sounds, bronchial respiration, and rhonchi were heard over the lungs. Dyspnœa increased. Tracheotomy was not performed, because the stenosis was not in the trachea but the bronchi. Death occurred through suffocation. The autopsy revealed ulcerations over the upper tracheal rings, over the bifurcation, and the bronchi where continuous with the lungs, along with lobular infiltration of the lungs.

The condition of the lungs was very similar to interstitial pneumonia. Syphilis can thus destroy the pulmonary parenchyma, as well as tuberculosis and pulmonary gangrene. MICHAEL.

**NEWMAN, DAVID** (Glasgow).—**Syphilitic Diseases of the Upper Air Passages; their Pathology, Symptoms, and Treatment. With Illustrative Cases.** *Glasgow Medical Journal*, December, 1886, and January and February, 1887.

IN these communications the author gives, in the form of two lectures, an accurate and careful *résumé* of his subject, with many illustrations of personally-observed cases. The paper is well worthy of perusal.

HUNTER MACKENZIE.

**HOLDEN, EDGAR** (Newark, N. J.).—**A Case of Gummatous Disease of the Larynx, with Spontaneous Re-opening of the Larynx, after Thyroid Laryngotomy.** *N. J. Med. Journal*, January 29, 1887.

A MINUTELY detailed case, the nature of which is indicated in the title of the paper. J. N. MACKENZIE.

**IRSAI** (Pesth).—**Laryngological Communications.** *Pesther Med. Chir. Presse.* No. 46, 1886.

ON tuberculosis. Nothing new. MICHAEL.

**AIKINS, W. H. B.** (Toronto).—**Laryngeal Tuberculosis.** (*Canadian Pract.*, March, 1887.

A PATHOLOGICAL specimen shown at the Toronto Medical Society, January 20, 1887. The larynx exhibited was covered on the vocal cords and arytenoid cartilages with tuberculous ulcers, in which tubercle bacilli were found in abundance. The interest of the case lay in the fact that no tuberculous deposits were found in the lungs.

**CRAWBERRY, D. B.** (King, Miss.).—**Ingenious Method of Extracting a Cockle-burr from the Larynx.** *Medical News*, Phila., December 11, 1886.

HAVING no instruments at hand, Crawberry wrapped some cotton around the end of his right index finger, which he then passed down to the burr, and by a rotatory movement, in order to entangle the cotton in its prickles, succeeded, after several attempts, in effecting its complete removal. J. N. MACKENZIE.

**KNIGHT, CHAS. H.** (New York).—**A Case of Perichondritis of the Larynx; Necrosis of the Cricoid.** *New York Med. Journal*, January 1, 1887.

RELATES a case, with post-mortem examination of the air-passages.

The carefully written history of the patient is supplemented by a review of the etiology of laryngeal perichondritis, and a brief reference to a case occurring in the service of Dr. Asch, in which perichondritis and abscess of the posterior wall of the larynx resulted from swallowing a plate of false teeth during an epileptic fit.

J. N. MACKENZIE.

**Statistics of Tracheotomies at the Hôpital Trousseau, and at the Hôpital des Enfants during the year 1886.** *Revue des Maladies de l'Enfance, March, 1887.*

HÔPITAL TROUSSEAU.—The number of croup cases operated on has been 363, of which 297 died and 106 recovered, making 29·23 per cent. of cures. The cases not operated on numbered 62, of which 54 recovered and 8 died.

Hôpital des Enfants: 355 children affected with croup were operated on, of which 60 recovered and 295 died, which gives the percentage of cures as 16·9 only. The difference of the two statistics is inexplicable.

JOAL.

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## NECK, &c.

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**FORT, J. A.—Cyst of the Thyroid Gland; Extirpation; Cure.** *Gaz. des Hôp., No. 6, 1887.*

THE tumour extended from the hyoid bone to the sternal notch, passing over the median line internally, and resting externally upon the internal jugular and carotid. Thyroidectomy was determined upon. During the operation the cyst emptied itself. The walls, containing cartilaginous and calcareous concretions were dissected out. No hæmorrhage occurred at the time, but after suturing the wound, secondary hæmorrhage supervened, which was, however, controlled without great difficulty. Antiseptic precautions were used. No vessels were ligatured.

**BEC, Le.—Sanguineous Cystic Goître: Puncture: Injection of Iodine. Cure.** *Gaz. des Hôp., No. 1, 1887.*

SIXTY grammes of clotted blood were removed on puncture. The nature of the case is indicated by the title.

**HURRY, J. B.—Case of Goître, followed by Asphyxia; Tracheotomy; Death.** *Lancet, March 19, 1887.*

THE goître was of a year's duration with increasing dyspnœa, which



ultimately called for tracheotomy. No mention is made of the laryngoscope assisting the diagnosis. No relief followed the operation, and the patient died. At the autopsy, the trachea was found to be laterally compressed by the two lobes of the enlarged thyroid. The author offers an explanation of the suddenly intensified dyspnœa, in supposing that the sterno-hyoid and thyroid muscles being called into requisition to supplement the laboured respiration, increase, thereby, the pressure of the gland on the trachea, a "vicious circle" being thus established.

GREVILLE MACDONALD.

**NICOL** (Hanover).—*Volubilitas Linguae.* *Deutsch. Med. Zeitung*, No. 11, 1887.

THE patient, twenty-five years old, could put his tongue behind the soft palate, so that nothing could be seen of it in the mouth. He was enabled thus to clear his naso-pharynx of mucus.

The author has also seen a man of thirty-five, who could perform the same feat.

MICHAEL.

**HOEPLIN** (Munich).—*Abscess of the Mediastinum Posticum.* *Munich Med. Woch.*, February, 1887.

THE patient was admitted into the hospital with urgent tracheal stenosis. Dr. Ziemssen found laryngoscopically, paresis of the crico-arytenoidei postici muscles and protuberance of the posterior tracheal wall. Some time later the patient had attacks of suffocation and fever. The dyspnœa decreased, with the expectoration of  $\frac{3}{4}$  litre of frothy pus within two days. He then left the hospital, but some months later died of pulmonary hæmorrhage. The autopsy revealed pulmonary phthisis, and an abscess behind the trachea filled with  $\frac{1}{8}$  litre of pus. No cause could be discovered for the abscess. The pulmonary phthisis was considered to be secondary.

MICHAEL.

**HITCHCOCK, N. G.** (N.Y.).—*Gummatous Infiltration of the Tongue.* *New York Med. Journal*, February 5, 1887.

REPORT of four cases. In none was the fibrous septum of the tongue the exclusive seat of the deposit, and in three the deposit did not approach this structure. In no instance was there neighbouring glandular enlargement. The cases bear out the assumption that the soft palate and tongue are more simultaneously involved in ulceration.

**BUCHANAN, GEORGE** (Glasgow).—*Salivary Fistula Cured by the Galvano-cautery.* *Glasgow Medical Journal*, February, 1887.

IN this case the fistula was formed by the incision necessary to relieve

an enormous carbuncle which was situated on the left side of the neck below the ear. The fistula had existed for thirteen years, and cicatrized after a single application of the galvano-cautery loop.

HUNTER MACKENZIE.

**MAYLARD** (Glasgow).—**Case of Lympho-Sarcoma of the Neck.**  
*Glasgow Med. Journ., February, 1887.*

EXHIBITION of case before the Pathological and Clinical Society of Glasgow, October 11, 1886. Patient aged four years. The growth commenced as a little tumour below the left ear, and had grown in seven months. It now occupied the whole of both sides of the neck, and the breathing was becoming affected. The tumour was free from the larynx, and movable on it. Latterly it had become very painful, and a severe cough had developed.

HUNTER MACKENZIE.

**MIDDLETON** (Glasgow).—**Salivary Calculus.** *Glasgow Med. Journ., February, 1887.*

EXHIBITION of specimen (for Dr. Macpherson, Cambuslang) before the Pathological and Clinical Society of Glasgow, October 11, 1886. The calculus was spontaneously discharged.

HUNTER MACKENZIE.

**LYALL, ANDREW.**—**A Case of Inflammation of the Deep Cellular Tissue of the Neck.** *Edin. Med. Journal, February, 1887.*

IN this case, dyspnœa developed to an alarming extent. Great relief, and ultimately recovery ensued after two incisions had been made—one about two inches below the jaw, in the line of the sterno-mastoid, and the other below, and in front of the angle of the jaw. From both incisions fetid pus and air escaped.

HUNTER MACKENZIE.

**SCHRÖTTER** (Wien).—**Carcinoma of the Lung or Tuberculosis?**  
*Allgem. Wiener Med. Zeitung, Nos. 48, 49, 50, 1886.*

A CLINICAL discourse on a rare case of combined carcinomatous and tubercular disease, in a man of thirty-eight, who for a long time had chronic phthisis of the lung, with carcinoma of the thyroid, compression of the trachea, and mediastinal lymphatic tumours. It was impossible to make a diagnosis during life.

MICHAEL.

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## REPORTS OF SOCIETIES.

## Academy of Medicine, Ireland.

*January 14, 1887.*

*Edema Glottidis in Bright's Disease.*—Dr. CHRISTOPHER DIXON exhibited the larynx and trachea of a patient who had died under his care of what it is the custom to call cedema glottidis, occurring in the course of Bright's disease.

*Friday, February 25, 1887.*

*Diphtheria.*—Dr. MOUILLOT read a short account of an outbreak of diphtheria which occurred in the female school of the Gorey Workhouse. Eighteen children were affected, and there was a remarkable difference in the severity of the cases. In seven, the appearance of the throat was that considered characteristic of diphtheria, and in three of these the local and constitutional symptoms were very severe. In ten cases, there was no means of distinguishing the appearance of the tonsils and pharynx from ordinary tonsillitis. In one case, the disease appeared to begin in the larynx. Out of the eighteen cases, three had laryngeal diphtheria, with two deaths; two cases were followed by diphtheritic paralysis, and sixteen had distinct enlargement of the cervical glands. Dr. MOUILLOT traced the disease to a foul smell arising from a choked drain immediately under the school-room and dormitory window. He considered that even the mildest cases were really diphtheria, because (1) all were produced by the same cause and at the same time; (2) one of the least severe was followed by paralysis of the palate; (3) the cervical glands were enlarged; (4) the children with mild sore throats were put in the same ward in the fever hospital with the certainly diphtheritic cases, and none of them caught a second attack, though the infectious nature of the disease was shown by a child in another ward, who was convalescent from typhus, catching it.—Dr. FRAZER, having seen a good many cases of diphtheria, could only satisfy himself that two had any connection with bad drainage. Dr. A. W. FOOT thought that real diphtheria was not as common as many believed. It comprised five conditions: (1) early and remarkable swelling of the lymphatic glands of the neck; (2) extreme fetor of the breath; (3) albuminous urine; (4) subsequent paralysis in some shape or other, either confined to a strabismus, or involving the four limbs, or, still worse, the central circulation; and (5) nearly all, or at least 50 per cent., had a fatal result.—Dr. FINNY agreed that genuine diphtheria cases were few and far between. Many cases attended with exudations of the throat were not of the true diphtheritic nature.—Dr. DUFFEY considered that Dr. Mouillot had demonstrated that the epidemic of diphtheria which he recorded was due to imperfect sewerage. No doubt there were ordinary cases of sore-throat due to the same cause. True diphtheria was indicated by constitutional symptoms and the sequelæ rather than the mere local manifestations.—The PRESIDENT (Dr. Little) said his observation of diphtheria accorded with Dr. Foot's in enabling him to set down the rate of mortality as at least 50 per cent. He had been disposed also to limit true diphtheria to cases having the four signs present which Dr. Foot had enumerated; but Dr. Mouillot's cases did not present those four characteristics, and yet the fact that they occurred together, and were followed by paralysis, indicated true diphtheria. Albumen in the urine was a very important characteristic, but there might be albumen in the urine in cases of sore-throat, too. He regarded croup and diphtheria as distinct diseases.—Dr. MOUILLOT, in reply, submitted that his cases demonstrated that diphtheria was not so fatal as was generally supposed.

**Leeds and West Riding Medico-Chirurgical Society.**

March 4, 1887.

THE following interesting experiences were related of the *Dangers of Cocaine*.—Mr. A. ROBERTS had amputated a breast for persistent neuralgic pain after the injection of sixty minims of a 6 per cent. solution of cocaine. No pain was felt, but the patient became blind, and talked incoherently for some hours; there was complete recovery.—Dr. ALBUTT referred to a symptom described by some after the use of cocaine, namely, dreams, in which writhing worms formed an important object. He had experienced this himself after applying cocaine to his throat.—Mr. HEWITSON spoke of corneal opacities produced by the use of cocaine in ophthalmic operations where a mercurial antiseptic was used.—Mr. LITTLEWOOD had felt a severe depression half an hour after the injection of cocaine for the removal of a nævus from his hand, but soon recovered. He had seen great loquacity and subsequent faintness produced in an old man in whom three grains had been injected.—Mr. OAKELY had seen bad effects from strong solutions, but found that the desired effect could be obtained by the use of not more than thirty minims of a 4 per cent. solution. He had found nitrite of amyl useful as an antidote.—Mr. MAYO ROBSON had had two cases only out of a large number which had caused him any anxiety, namely, one in which severe syncope followed an operation for circumcision, and another where aphasia lasting four hours followed the use of cocaine for the removal of a nasal polypus.—Dr. WARDROP GRIFFITH, after the injection of cocaine for the incision of an abscess on his finger, experienced a feeling of languor and weakness, like that produced by morphine, and a condition of general anaesthesia, in which he could pierce his tongue and limbs with needles without feeling pain.—Dr. PURDY had seen severe pain in the eye caused by a cocaine disc. He spoke of the convenience of carrying the drug in half-grain powders, which were easily dissolved.—Mr. HARTLEY had seen no bad results in a large number of cases in which weak solutions were used.—Mr. J. TEALE thought it important that the maximum safe dose should be decided.—Mr. PRICE and Mr. C. S. WRIGHT had used cocaine (a 5 per cent. solution in lanolin) satisfactorily in cases of vaginismus.

At the same meeting Dr. CLIFFORD ALBUTT described the *Last Days of a Case of Graves's Disease*.—He was called to a lady almost moribund, with symptoms of failing heart, accompanied by dropsy and congestion of lungs. The heart's action was quick, but no valvular lesion could be detected. The action resembling that found in Graves's disease, inquiry was made, and a clear history of enlarged thyroid and exophthalmos elicited. These symptoms disappeared two years before.

**Brighton and Sussex Medico-Chirurgical Society.**

March 3, 1887.

*Rhinolith*.—Mr. CRESSWELL BABER read notes of a case of rhinolith occurring in a girl aged twelve. There had been offensive discharge and bleeding from the left nostril for six years. In the left nasal passage, which was impervious and blocked with granulations, a hard body was detected about an inch and a half from the tip of the nose. On removal through the nostril, it proved to be a filbert-shaped calculus, having a nucleus of tightly-pressed folds of rag. No diseased bone was detected, and the case did well.

*Pulsating Vessel on the Posterior Wall of the Pharynx*.—Mr. CRESSWELL BABER mentioned the case of a lady who consulted him for deafness, in whom, on examining the pharynx, a vertical pulsating vessel, forming an eminence of the diameter of a slate pencil, was seen in the position of the left salpingo-pharyngeal fold. The vessel was probably an enlarged ascending pharyngeal artery.

**The Medical Society, London.**

*Meeting, February 28, 1887.*

Mr. LENNOX BROWNE exhibited a patient from whom he had ten weeks previously excised the left half of the thyroid and cricoid cartilage with the corresponding arytenoid, vocal cord and internal soft parts, on account of unilateral epithelioma in a male patient aged sixty-one. The following points were emphasised:—1. Use of the raspatory for removing the tissues external to the cartilage as the surest safeguard against hæmorrhage, as lessening the chance of septicæmia, and ensuring speedy recovery of the power of swallowing, &c. 2. The use of Hahn's tampon canula. 3. The use of perchloride of mercury in solution, and of corrosive sublimate gauze in preference to iodoform, as dressings for the wound. 4. The not too quick closing of the external wound, with the view of prolonging functional rest of the larynx without the irritation of a tracheotomy tube. The patient spoke with a fair gruff voice, and was able to resume his occupation, but Mr. BROWNE considered that it was too early a period yet to speak as to the freedom from recurrence.

*Tuberculosis of Fauces, &c.*—Mr. LENNOX BROWNE also showed a young woman the subject of tuberculosis of the fauces and pharynx, extending to the posterior wall of the larynx and slightly involving the right arytenoid cartilage. The lung condition showed only incipient phthisis, but bacilli of tubercle were plentiful at the seat of ulceration. The patient had suffered on admission into the hospital on December 4 from dysphagia in such an extreme degree that she preferred not to take food. According to the method advised by Krause, of Berlin, the diseased surface, previously anæsthetised by cocaine, was scraped, and solutions of lactic acid, 20, 40, and 60 per cent., were applied daily for twenty-one days. At the end of that period acute inflammation took place, on recovery from which the dysphagia was found to be absolutely relieved.

**Berlin Medical Society.**

*Meeting, December 15, 1886.*

Dr. BRAMAN demonstrated two cases in which he succeeded in healing the dismembered tips of the nose.

Dr. KOCHLEK exhibited a case of sarcomatous struma.

Dr. LAZARUS showed a bone which had been coughed up by a patient. It had been inspired two months before during swallowing. The same day hæmoptysis occurred, which lasted for twenty-four hours, accompanied with pains in the chest, leading to the impression that the case was one of commencing phthisis. The bone was finally expectorated with a good deal of blood.

Dr. SCHOLTZ exhibited a rhinolith formed round a cherry-stone, which had occurred in a patient sixty-two years old.

**Wurzburg Medico-Physical Society.**

*Meeting, February 12, 1887.*

Dr. SEIFERT referred to a case of myxo-fibroma, which commenced in the right lower nasal meatus, and could only be seen by posterior rhinoscopy. It was removed by Michael's forceps. In the stalk was a cavity filled with fluid. The substance of the tumour was mucous and connective tissue.

**Buda-Pesth Royal Society of Physicians.**

*Meeting, January 30, 1887.*

Prof. EMERICH NAVRATIL demonstrated a case of *bilateral paralysis of the vocal cords*. The patient was fifty-eight years old, and had arterio-sclerosis. The



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present affection occurred suddenly in the night. On awaking he could neither speak nor swallow. Examination of the œsophagus showed a stenosis, but the mucous membrane was intact and not ulcerated. The vocal cords were immovable on phonation. The sudden onset of paralysis was probably due to acutely increased aneurism of the aortic arch, by rupture of the internal coat.

### **Society of Physicians in Vienna.**

*Meeting, February 4, 1887.*

Prof. STÖRK showed a man, who when a child had a laryngeal papilloma, which had fifteen years afterwards, developed into carcinoma. In 1885, extirpation of the larynx was performed. The patient now speaks and swallows quite normally. A new glottis has developed out of the muscular structure of the larynx.

Prof. STÖRK also showed an electrical laryngoscope.

*Meeting, February 18.*

Dr. SALZER, showing a case of tubercular ulcer of the tongue, remarked that in order to demonstrate tubercle bacilli, it was not necessary to excise any portion, but simply to scrape the ulcer.

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## **REVIEWS.**

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### **SCHRÖTTER (Wien).—Lectures on Diseases of the Larynx the Air Passages, the Nose, and the Pharynx.<sup>1</sup>**

THE publication of Schrötter's Lectures will be received with great interest in laryngological circles, particularly among those numerous German, as well as English and American, laryngologists who have studied in Vienna. Judging from the first part now before us, the book will find favour with the practical physician. The first lecture supplies a short historical retrospect of laryngoscopy. If more honour is here accorded to Türck and Czermak than to Garcia, we must attribute the fact to Austrian patriotism. In our opinion Türck and Czermak are only honourable successors of Garcia. For illumination, the author recommends Türck's frontal band reflector, and says that no other front bands are so practical as this. The focus of the reflector should have a diameter of 10–12 cm. For illumination he has used Auer-Welsbach's light with great advantage over all others (see the report in this Journal). The author believes it to be better than other methods of illumination, such as electricity and magnesium.

The third and fourth lectures give a good *résumé* of the anatomy and physiology of the larynx; the fifth is occupied with details of

<sup>1</sup> *Vorlesungen über die Krankheiten des Kehlkopfes, der Luftröhre, der Nase und des Pharynx. First Part, with 13 Woodcuts. Wilhelm Braumüller, Vienna, 1887.*

laryngoscopical examination, magnifying of the laryngoscopical image, autolaryngoscopy, and demonstrations. The work will be published in ten parts. MICHAEL.

**BAUMGARTEN** (Buda-Pesth).—**Epistaxis and its Treatment, from a Rhino-Surgical Point of View.**<sup>1</sup>

THE introduction of anterior and posterior rhinoscopy inaugurated a new era of treatment of epistaxis. It is now possible to find the exact seat of the mischief, and treat locally and directly. The author differentiates those cases of epistaxis arising from a general cause from those which originate in a definite pathological condition in the nose itself; and from another group of cases, in which the nose is only a seat of epistaxis by reason of special predisposition. The portions of the nose concerned in this latter group are little erosions, or varices, particularly on the septum, or choanæ, which give rise to bleeding through an increase of pressure, or by accidental causes, such as scraping the nose, or sneezing. It is easy to cure this form of the complaint, by cauterizing the implicated spots with chromic acid, nitrate of silver, or by the galvano-cautery. All local diseases of the nose may give rise to epistaxis, *e.g.*, acute and chronic rhinitis, ozæna, hypertrophy of the choanæ, polypi, and other neoplasms, ulcerations, and all kinds of parasites. The epistaxes occurring in general diseases are often localised in the specially predisposed spots of the nose. Such general diseases are chiefly cardiac, pulmonary, hepatic, splenic, renal, diseases of the great blood-vessels, plethora, and hæmophilia, along with many of the acute infectious fevers, especially recurrent fever. The vicarious epistaxes of menstruation were already known by Hippocrates.

The quantity of blood lost during an attack of epistaxis may vary from a few drops to four or five kilogrammes, and may last from one minute to several days. If anterior tamponing is employed, blood may occasionally pass into the pharynx. In a few cases blood escapes by the lachrymal canal. (I have recently seen such a case.—Rev.) The prognosis of epistaxis is good if it does not arise in the course of a general disease.

The treatment of epistaxis consists in compression of the bleeding spot by anterior and posterior tamponing. (Anterior tamponing suffices for most cases.—Rev.) The different methods of using the tampon are well described. To prevent recurrence, the bleeding spot must be cauterised. The book closes with a complete bibliographical index. MICHAEL.

<sup>1</sup> *Die Epistaxis und ihre Behandlung vom rhino-chirurgischen Standpunkt.* Vienna, 1886. Toeplitz und Denticke, 47 pages.

**WÖLFLE** (Wien).—**The Surgical Treatment of Goître.**<sup>1</sup>

THIS is a medico-historical essay. The author has for some years devoted attention to the surgery of goître, and relates the history of the operative treatment of this disease, commencing with Celsus and ending with Billroth and his pupils. A tabular *résumé* of all operators follows, under different methods of treatment, and the author exhibits, in the form of a curve, the important periods in the history of this treatment. It is impossible, in a short report, to give a detailed account of this book. It is remarkable for its completeness, and may be recommended to all who have any interest in the surgery of goître, as well as to those who have a fancy for medico-historical studies. Such a book as this may be taken as an example of what all similar essays on this, or any other branch of our science should aim at being—concise, lucid, and exhaustive. MICHAEL.

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## NOTES.

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**The name of Dr. G. W. Major**, of Montreal, is this month added to the list of our collaborateurs.

**Prize.**—The prize of 1,000 francs offered by the Société Auxiliare des Sciences, of Geneva, was recently awarded to Dr. L. Mégevand, of Geneva, for his memoir entitled, “Anatomo-Pathological Study of Diseases of the Vault of the Pharynx.” The author’s work is based on the study of 100 original observations in the anatomy and pathology of this region (*Rev. Méd. de la Suisse Romande*, January, 1887).

**Jubilee of Professor Politzer.**—A committee, consisting of Messrs. Urban Pritchard (London), A. Joly (Lyons), E. Morpurgo (Trieste), V. Grazi (Florence), E. Pius (Vienna), F. Rohrer (Zurich), A. Kühnman (St. Petersburg), has been engaged in collecting subscriptions (of 10 francs) from the admirers of Professor Politzer, for the purpose of presenting this celebrated teacher with his portrait at the next occasion of the meeting of otologists at Vienna, together with a list of the subscribers in the form of a souvenir. A heliograved reproduction of this portrait will also be presented to each of the subscribers. Subscriptions were invited to be sent to any of the members of the Committee before the end of March.

**Iodine Stains.**—It is said in the *Répertoire de Pharmacie* for 1886 that the disagreeable yellow stains left upon the skin by iodine may be removed by dilute ammonia, soda, charcoal, or common soap in cases where the integument is

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<sup>1</sup> *Die Chirurgische Behandlung des Kropfes.* Hirschwald. Berlin, 1887. 89 pages.

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hardened. In persons of delicate skin, pencilling the stained surface with solutions of  $\frac{1}{1000}$  —  $\frac{1}{10}$  sulphite of soda, or application of compresses saturated with this solution, will absorb iodine both by the acid and the base, and will cause rapid disappearance of the pain and irritation produced by the iodine application.

**Periodicals, Pamphlets, &c., received.**—*Gazette des Hôp.*, *La Pratique Médicale*, *Le Progrès Méd.*, *Ann. des Mal. de l'Oreille*, etc., *Rev. Méd. de la Suisse Romande*, *Edinburgh Med. Journal*, *Birmingham Med. Review*, *Canadian Practitioner*, *New York Medical Journal*, *Boston Med. and Surgical Journal*, *Philadelphia Med. Times*, *Therapeutic Gazette*, *Boll. delle Mal. dell' Orecchio*, etc., *Revista de Laringologia*, etc., *Anales de Otoligia y Laryngologia*, etc., *Gaceta de Oftal. Otol. y Laringol.*, *Faits Cliniques relatifs aux Polyypes Muqueux des Fosses Nasales*: Luc. *Note Cliniche su due Cassi di Carie della Mastoide*: Felici. *Ein Unicum in der Laryngo-Chirurgie isolirte Extirpation des Ringknorpels wegen Enchondrom*: Böcker. *Verkrümmungen und Callösen Verdickungen der Nasensecheidewand. Die Sogenaunte Rachentonsille. Ein Fall von Spasmus Glottidis*, etc.: Bresgen. *Lesioni sulle Malattie dell' Orecchio*: Cozzolino. *Ueber die Transformation von Schleimpolyphen*: Bayer. *Treatment of Laryngeal Tuberculosis by Submucous Injection of Lactic Acid. An Improved Nasal Traction Snare*, etc. *Prolapse of the Laryngeal Ventricles*: G. W. Major. *Abscès du Sinus Maxillaire Gauche Simulant un Ozène*, etc.: Luc. *The Question of Hemorrhage following Uvulotomy*: E. C. Morgan.

*Letters relating to the Editorial business of the Journal are to be addressed "To the Editors."*

*Business communications to be sent to the Publishers, Messrs. J. & A. Churchill, 11, New Burlington Street, London, W.*

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THE LOCAL TREATMENT OF  
LARYNGEAL PHTHISIS.

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THE local treatment of laryngeal tuberculosis is a subject upon which a large and continuous amount of labour has been bestowed with somewhat varied results. Therapeutic attempts may be limited to subduing the inflammation, and mitigating the pain which accompany the disease, or they may run in the direction of finding a specific remedy for it. If a drug were known which could eradicate the disease, discussion of the subject would be no longer necessary. Unhappily, however, an impartial critic must admit that such a remedy does not exist, for the enthusiasm with which each successive remedy has been presented by its discoverer has been but the harbinger of declarations of failure by other workers.

In this respect, laryngeal tuberculosis is not different from many other diseases, for most remedies have short lives. So far as laryngeal phthisis is concerned, we can with confidence say that, whilst a specific remedy is non-existent, we can do now much more in the way of local treatment than we could a few years ago. The cicatrization of tubercular ulcers is not only proven by many recorded cases, but every one who is well acquainted with the laryngoscope must have observed instances of spontaneous cicatrization of such ulcers when situated in the larynx.

This fact is in complete accord with the pathology of the disease. It is well known that tubercles are disposed in superficial layers, and that the necrobiotic process or stage can end with the total elimination of the morbid product. When this takes place in the larynx, it is exceedingly interesting to determine whether the recovery, as evidenced by the presence of cicatrization, is of a local nature, or whether it also means cure of a general tuberculosis. On this point it is probable that the great majority of the profession will be inclined to concur with the writer when he asserts that, not-



withstanding the healing of the local (laryngeal) lesions, a patient does not become free from tuberculosis. This, however, ought not to prevent us making judicious use of local treatment, with this prevision that every honest physician will be careful to explain to his patient that a local cure may not necessarily affect the general disease.

It is not the intention of the writer to enumerate all that has been done in regard to the local treatment of laryngeal phthisis since the invention of the laryngoscope. We now award a merely secondary place to the use of antiseptic sprays and inhalers, at one time very much in vogue. The local application of nitrate of silver, iodine, opium, and the mineral astringents, is now supplanted by other and more efficacious remedies and methods; of these it is necessary to write in some detail in order to determine, if possible, which remedy or method of treatment is to be preferred.

In 1880, it was proposed by Moritz Schmidt, of Frankfort, to treat laryngeal tuberculosis by free scarification with scissors, under complete asepsis. To many it must have been difficult to recognize how, or by what *modus operandi*, a cure of tubercular disease could in this manner be effected. The method found few supporters, and the most that can be said about it is, that it has now sunk into well-deserved oblivion. Schmidt,<sup>1</sup> with whom I concur, recommends inhalations of balsam of Peru as having a remarkably effective sedative action. Cauterization, with the view of protecting the tissues from the contact of food and drink, has now been largely displaced by remedies with more radical indications, and opium, morphia, belladonna, and similar drugs have found in cocain a serious competitor, whose place as a local anæsthetic neither menthol nor caffen have affected. Unfortunately, whilst the effects of cocain are astonishing, they are but transitory in nature, and the drug is consequently of a merely symptomatic value.

Amongst the oldest and most widely-used drugs in the treatment of this disease stands iodoform. Literature does not enlighten us in regard to the individual who first employed iodoform in the local treatment of laryngeal phthisis. The writer was taught to use it by Elsberg, in 1880, and with him prefers the ethereal solution to the powder, in the strength of 1 in 3. Since using iodoform in this way, the writer has had marked beneficial results in his practice, but he

<sup>1</sup> Schmidt recommends steam inhalations containing 20-30 drops of the following mixture to a pint of hot water:—

Balsam of Peru	...	...	...	...	10 grms.
Alcohol	...	...	...	...	5 "

is only able to recall one case in which complete recovery ensued. Iodoform has of late been to some extent displaced by lactic acid. As a result of repeated trials of the latter, the writer is of opinion that, notwithstanding the warm recommendations of this remedy by Krause, Schrötter, Jelinek, and Hering, it is far inferior to iodoform as a local therapeutic agent, and in this opinion he is certain the mass of the profession will concur. He has now, in fact, completely discarded lactic acid, and has returned to iodoform. The writer may say that he has not tried the sub-mucous injection of lactic acid (about 1 grm. of a 20-30 per cent. solution with Hering's syringe as modified by Krause), but of this he feels certain that, applied in this way, neither can the pain be less nor the effects different than when the more common methods of application are employed. The sub-mucous method is not exempt from practical difficulties which all the more detract from its applicability, as the treatment of laryngeal phthisis should be one which every practitioner of medicine ought to be able to employ. The application of iodol in powder has, in the writer's experience, been productive of better results than lactic acid, but not better than iodoform. The results obtained have agreed with those of Lublinski, who, in careful and unexaggerated language (very different in this respect from most discoverers of new remedies), first described its effects. On the whole, however, the writer is inclined to prefer iodoform to iodol.

The probably parasitic nature of tubercular disease has suggested to the writer the prophylactic use of mercurial sublimate, of the strength of 1 in 2,000. The indication is so rational, the practice so simple, the tolerance so complete, and the effects so satisfactory, that he now universally adopts it in practice.

The writer has not had experience of warm air, recommended by Fournier, as an anti-microbiotic and prophylactic agent, and as favouring the formation of crusts or scabs on the ulcerated surfaces. This necessarily implies somewhat continuous treatment, to which patients might occasionally object.

In all cases, the difficulty of diagnosis in primary tubercular laryngitis is great, and is experienced all the more in the contemplation of another remedy, of an essentially radical nature, namely, extirpation of the larynx. The history of many successful cases of extirpation of glands, kidneys, ovaries, and other organs for tubercular disease warrants us in entertaining the idea that, were early diagnosis of primary laryngeal phthisis possible, extirpation of the larynx in such instances would come within the pale of justifiable surgery, and take its place as the most efficacious of all remedies.

The writer's views may be shortly summarized as follows :—

(1) We are still in want of some remedy, or remedies, to effect the cure of laryngeal phthisis.

(2) Notwithstanding this want, the local (palliative) treatment of the disease is incumbent upon every physician.

(3) Many of the cases quoted by various writers are of an extremely hypothetical nature, inasmuch as they have not been a sufficient time under observation.

(4) Cocain, iodoform, iodol, and sublimate are perhaps the best of all local remedies. Lactic acid, even by submucous injection, does not appear to have led to favourable results.<sup>1</sup> J. M. (Naples).

## INSTRUMENTS AND THERAPEUTICS.

**MANDEVILLE, F. A.** (Rochester, N.Y.).—**A New Reversible Amygdalotome.** *New York Med. Journal*, March 5, 1887.

This is an improvement of Mackenzie's well-known instrument, the handle being attached to the knife so as to allow of its revolving round it, a spring-bolt fixing it at the desired spot, which is controlled by the thumb of the operator drawing a slide placed in the shank of the handle. The instrument can thus be very quickly reversed.

**KRAUSE** (Berlin).—**Instruments.** *Monats. für Ohrenheilk.*, No. 3, 1887.

1. A palate hook which can be fixed on the upper lip.
2. Curved trocar for opening the antrum of Highmore.  
A trocar, *à double courant*, for the same purpose.
3. A nasal saw.

MICHAEL.

<sup>1</sup> Tracheotomy and intubation of the larynx are valuable resources in laryngeal phthisis. The writer has not mentioned them in the above communication, as they are universally accepted under appropriate circumstances. Forced alimentation is another important therapeutic adjuvant. Rectal injections of sulphur with carbonic acid gas have been proposed by Bergeon, of Lyons, in phthisis, and special reference has been made to its applicability in the laryngeal variety of the disease (*vide Progrès Medical*, No. 3, 1887, p. 51). As in this communication no laryngoscopic observations are recorded, and as the method is still on trial, the writer contents himself with merely making reference to this certainly ingenious and original method of treatment. Inhalations of *bacterium termo*, as proposed by Prof. Cautani, appear to have no influence whatever either in pulmonary or laryngeal phthisis.

**NYROP** (Copenhagen).—**Electric Light for Medical Purposes** *Monats. für arztl. Polytechnik*, No. 2, 1887.

A DESCRIPTION of accumulators, electrical laryngoscope, etc.  
MICHAEL.

**SANZ, F.**—**Abortive Treatment of Catarrhal Amygdalitis.** *Revista de Medicina y Cirugia Prácticas*, Enero 22, 1887.

IN *El Genio Médico-Quirúrgico*, Dr. Sanz advises from the first appearance of throat symptoms a lozenge of guaiacum, and he avers that the disease will disappear within twenty-four hours. If the complaint has existed for some hours, or for one or two days, he adds to the lozenge two centigrammes of extract of rhatany: if fever is a prominent symptom he gives antipyrin, and in every case pays attention to the gastric symptoms.

RAMON DE LA SOTA Y LASTRA.

**BAKER, W. J.**—**Treatment of Tonsillitis.** *Brit. Med. Jour.*, April 9, 1887.

A CLINICAL memorandum strongly recommending bicarbonate of soda.

**CHIARI** (Vienna).—**On the Use of Cocaine in the Treatment of Diseases of the Throat, Nose, and Larynx.** *Wien. Med. Woch.*, Nos. 7, 8, and 9, 1887.

A VERY complete review of a great number of publications referring to cocaine and its uses as an application to the mucous membrane of the upper respiratory passages.  
MICHAEL.

**FEINBERG and BLUMENTHAL.**—**Further Communications on the Physiological Action of Cocaine.** *Berlin Klin. Woch.*, No. 10, 1887.

1. Cocaine is a powerful anæsthetic.
2. The anæsthesia is limited to the site of application.
3. Applied to a freely exposed nerve, it produces local anæsthesia, which spreads to the periphery, the central end and motor function not being altered.
4.  $\frac{1}{2}$ –1 gramme produces in rabbits and dogs anæsthesia of the cornea, dilatation of the pupils, retraction of the eyelids, and exophthalmos.
5. Cocaine produces certain respiratory troubles.
6. It also produces affection of co-ordination in the extremities.

7. 1-2 grammes in a rabbit, or 2-3 grammes in a dog, produces toxic and clonic spasms, with death.
8. The spasms are epileptiform, and accompanied with loss of sensation.
9. The intoxication in dogs begins with excitation of the sense organs, and depression follows.
10. The spasms are of cortical origin.
11. Cocaine is the best method of proving the dependence of epilepsy upon the central cortical substance.
12. Both in dogs and rabbits, cocaine produces anæsthesia of the nerve trunks.
13. Cocaine has a special relation to the sensory and terminal sensorial fibres of the cortex.
14. The disorders of co-ordination may be of central as well as of peripheral origin.
15. The spasms are produced through vaso-motor spasm and central anæmia.
16. The spasms are the direct cause of death.
17. Spasms can be averted by potass. bromid. and application of ice.
18. The application of warmth also ameliorates the cocaine symptoms by producing hyperæmia.
19. Amyl nitrite is the best means of treating cocaine poisoning.

MICHAEL (Hamburg).

**KNICKERBOCKER, F. (Vpsilanti).—The Treatment of Acute Coryza.** *American Lancet, February, 1887.*

THE writer suggests the administration of atropine.<sup>1</sup> "One-sixtieth of a grain, given in the stage of frequent sneezing and the beginning of the watery discharge, will soon remove all obstruction from the nares. The effect should be kept up from twenty-four to thirty-six hours." The following snuff is "soothing to the irritated membrane, excludes the air from direct contact with it, and also powerfully constricts the arterioles":—

R Morphine sulph. gr.  $\frac{1}{4}$ – $\frac{1}{2}$ .  
Cocaine hydrochlor. gr. iij.  
Bismuthi subnit. gr. v.  
Pulv. acacia gr. v.

M. et trit. *Siç.* Use as a snuff, or with insufflator.

<sup>1</sup> A pill of half a milligramme (0.0077 grain) of sulphate of atropin was strongly recommended in the *Lyon Médicale*, June 25, 1882, to cut short an attack of acute coryza. It was then said to be remarkably efficacious in arresting the sneezing and nasal flux, one dose being in most cases quite sufficient.



**ARIZA, RAFAEL.**—**The Therapeutic Value of Tracheotomy.** *El Siglo Médico*, February 6, 1887.

IN a lecture given in the Instituto de Terapéutica Operatoria, Ariza advised that in cases of acute laryngitis tracheotomy should be deferred until the patient is in imminent danger of death, since in many cases the alarming symptoms will subside in the course of the evolution of the disease; while in chronic laryngitis we should operate before asphyxia appears if it should seem certain to occur, because a narrowed glottis does not allow endo-laryngeal medication without considerable danger to the patient, and it is important to ensure a sufficient amount of air before pulmonary complications arise. The author is assured of the beneficial effects of tracheotomy in the cure of grave laryngeal diseases, and after showing the differential diagnosis between laryngeal syphilis, tubercle, and cancer of the larynx, he proceeds to prove his case by the exhibition of several patients who had been cured of their laryngitis by the operation.

RAMON DE LA SOTA Y LASTRA.

**OLTUSZEWSKI.**—**Lactic Acid in Laryngeal Phthisis.** *Medycyna*, No. 4, 1887.

VERY detailed observations on nine cases of tubercular ulceration of the larynx, in which phthisis has always been stated by the condition of the lungs and the detection of tubercle bacilli. By employing locally frictions of lactic acid, in strength of 10 per cent. up to 100 per cent., the author has obtained in six cases complete cicatrization, and in one case incomplete cicatrization. In one case there was amelioration of deglutition, and in another no benefit. The author finds that lactic acid acts best upon the superficial ulcers located upon the vocal cords and epiglottis. In cases of ulceration and infiltration of the adjacent parts it acts best after previously curetting the implicated parts. If granulations remain after cicatrization it is necessary to cauterize them with chromic acid. Cicatrization of the ulcers does not preclude the probability of their recurrence after a longer or shorter lapse of time. It does not arrest the march of the disease in the lungs. It is only by relieving the dysphagia that it facilitates nutrition and thus prolongs life. The number of applications, or rather frictions, with lactic acid necessary to obtain cicatrization are from 12 to 20, and it is necessary to make these applications with some force.

CONST. KARWOWSKI.

**LAZARUS** (Berlin).—**Asthma Therapeutics.** *Berlin Klin. Woch.*, No. 7, 1887.

A GOOD review of the various methods of treating asthma.

The following results are arrived at:—

1. The prophylaxis of bronchial asthma requires a report of the hereditary and constitutional conditions present, and especially of the condition of the mucous membrane of the nose and throat.
2. The asthmatic attack must be suppressed as soon as possible. The best medicament for this purpose is iodide of potash and chloral. In special cases operative treatment of the nose and naso-pharynx is recommended.
5. The treatment of the secondary affections is the more important in that they may become causes of recurrence of the asthma. For these conditions the best treatment is the pneumatic chamber. In chronic catarrhal conditions of the bronchi the best treatment is turpentine and iodide of potash.

MICHAEL.

**KRAUSS** (Winnenthal).—**The Therapeutics of Respiratory Diseases.**

*Monats. für Ohrenheilk.*, No. 8, 1887.

A RECOMMENDATION of diaphoresis in catarrhal affections.

MICHAEL.

**STOERK** (Vienna).—**Intubation of the Larynx.** *Wien. Med. Presse*,

No. 12, 1887.

IN consequence of the favourable communications of O'Dwyer, the author has endeavoured in many cases, without special indications for intubation, to introduce the tubes into the larynx. He found that he could accomplish the desired object in every case. Sometimes he applies cocaine first.

He has also invented a new instrument for the introduction of the tubes, an illustration of which is given.

MICHAEL.

**KEPPLER** (Vienna).—**On the Treatment of Whooping-Cough.**

*Wien. Med. Blatter*, No. 5, 1887.

INHALATION of tar has yielded good results in some cases. It also acts as a prophylactic.

MICHAEL.

**SONNENBERGER** (Worms).—**On the Pathogenesis and Therapeutics of Whooping-Cough, and a New Method of Treatment of the same.** *Deuts. Med. Woch.*, No. 14, 1887.

A REVIEW of the literature of the subject, and a recommendation of the internal application of antipyrin, by which drug the author has cured seventy cases in three to five weeks.

MICHAEL.

**MARCUSE** (Berlinchen).—On Whooping-Cough. *Inaugural Dissertation, Berlin, 1887.*

THE examination of the larynx in whooping-cough has yielded the author negative results. The insufflation of benzoin into the nose, as recommended by Michael, has been employed by him in some cases without result.

MICHAEL.

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## DIPHTHERIA.

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**GARRE.**—How to Prevent Infection by Aspiration of Diphtheritic Membranes from the Trachea. *Correspond. Bl. für Schweizer Aerzte, 1886.*

THE author recommends that the mouth of the catheter be closed with a plug of cotton wool, or that the catheter be jointed by a piece of drainage tube to a glass tube, and a plug of cotton wool be introduced. This has the same effect as the cotton wool used in bacteriological filters.

MICHAEL.

**JAMONT.**—Treatment of Diphtheria. *France Méd., March 12, 1887.*

A BIBLIOGRAPHICAL review and *résumé* of recent works on the subject. Nothing new.

JOAL.

**WERNER** (Markgronnigen).—A Rare Symptom in Diphtheria of the Fauces. *Wurtemberg Correspondenzblatt, No. 7, 1887.*

IN a case of diphtheria in a child of eight months of age the author saw, twelve to eighteen hours before death, black spots on the under lip diffusely spreading and seated on the skin. These spots reappeared if brushed away. A short time after the mother, who had been sitting on the bed and cleansing the child's nose and mouth, saw the same black points appear on the back of her own hands, but could not remove by brushing. Antiseptic washes would not remove them either. Some weeks later they were scraped away with a knife. The points in question were very similar to the black spots produced by burning with gunpowder. No other cases were observed during this epidemic.

It is a pity that a microscopical examination was not made. It is impossible to say whether or not there was a microbe present.

MICHAEL.

**FOCA, GENARO.**—Treatment of Diphtheria by Oxalic Acid. *Rev. de Med. y Cirug. Prácticas, Enero 7, 1887.*

NINE cases of diphtheria were cured by the author by the administration of a potion containing 1·50 grammes of oxalic acid, 150 grammes of infusion of green tea, with 30 grammes of syrup of bitter orange peel.

RAMON DE LA SOTA Y LASTRA.

**BANZÁ-JOAQUIN.**—One page more on Diphtheria. *Rev. de Med. y Cir. Prácticas, February 22, 1887.*

BANZA has published an article in *El Genio Médico-Quirúrgico*, in which he endeavours to show that diphtheria being an infection, general treatment is of the greatest importance, and that local treatment must be simple, since if it does not cure it at least can do no harm. He maintains that it is a very pernicious practice to persist in attempts to destroy the false membrane with energetic caustic solutions in a region in which, by reason of the age of the patient, we act blindly; and cauterize the sound parts perhaps even more than those which are diseased. The means to be employed should, according to the author, be those which cleanse the parts, and favour the spontaneous separation of the membrane.

RAMON DE LA SOTA Y LASTRA.

**KACZOROWSKI.**—Some words à propos of the Treatment of Diphtheria. *Przegląd Lekarski, No. 1, 1887.*

It is necessary to consider two factors in the treatment of diphtheria, viz., the local affection, and the consecutive septicæmia. The former is dependent upon specific bacilli, and presents no danger so long as it remains localized. Danger only commences when the infiltrated parts soften and ulceration is produced. At this period the streptococcus pyogenus of Rosenbach appears, and is propagated throughout the organism. Therapeutics must be directed to limitation of the local process, and to the avoidance of all means which could irritate the mucous membrane and produce collateral inflammation. The author employs the solution of chloride of sodium, 1 per cent., with tincture of iodine, 0·5 per cent.; at first given in doses of a spoonful every half-hour, and when improvement appears, every two hours. Under this treatment the false membranes and the infiltration gradually disappear without further trouble. The author employs the same solution as a gargle. Immediately ulceration and signs of general infection appear the author administers alcohol and aromatic remedies, externally and internally. Of these remedies the author gives the preference to camphor and benzoic acid.

CONST. KARWOWSKI.

**FORCHEIMER, F.** (Cincinnati). — **The Prognosis of Croup.** *American Lancet*, February, 1887.

AGE, power of resistance, temperature, intensity and extensiveness of the affection must be carefully weighed. There are epidemics in which the mortality is frightful, do what we may. The greater the asphyxia, or the presence of much albuminuria, or of hæmaturia, or change of the cough to dry, and cessation of expectoration after operation, the prognosis is grave. A sudden rise of temperature is serious. Increased frequency of respiration is suspicious. The author finds intubation fulfil all the indications of tracheotomy, and the patient stands a much better chance with the former. One or other, or both operations, are to be performed in all cases, irrespective of age, sex, or condition. The author has performed intubation in five cases with effectual relief of stenosis.

**TISSIER.**—**Diphtheritic Laryngitis in the Adult, Absence of Pharyngitis and Pseudo-Membranes in the Pharynx.** *Cure* *Ann. Mal. du Larynx, &c.*, March, 1887.

THE author records this observation, not because he thinks it rare, but to draw attention to the fact that in default of laryngoscopic examination, numerous cases of the same nature may pass unnoticed, and thereby entail mistaken diagnosis and even serious consequences. Many cases of contagion, apparently unintelligible, may find their true explanation in such a condition. These cases prove how necessary it is to use the laryngoscope methodically.

JOAL.

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## TONSILS, PHARYNX, &c.

**NACHTIGALL** (Stuttgart).—**Double Uvula.** *Deuts. Med. Zeit.*, No. 29, 1887.

BETWEEN the uvula and the left wall of the pharynx there was an appendage similar to a uvula, and joined to the true uvula by a thin band. A second band joined the structure to the palato-glossal arch. It was cut off with scissors, and proved to be composed, microscopically, of muscle.

MICHAEL.

**WAGNER, CLINTON.**—**Alarming Hæmorrhage after Tonsillar Excision arrested by Torsion of the Artery.** *New York Med. Journ.*, April 16, 1887.

THE patient was an adult. An artery of considerable size between



the pillars, and apparently springing from the root of the tongue, was twisted, and hæmorrhage arrested. The author concludes by stating that for the past eleven years he has used Mackenzie's in preference to Fahnestock's guillotine, which he formerly employed, and this owing to accidents occurring similar to those reported in the *Journal* for April, 1887.

**FARLOW, J. W.**—Five Cases of Large Visible Pulsating Artery on the Posterior Wall of the Pharynx, with Remarks. *Boston Med. and Surg. Journal*, March 31, 1887.

AFTER relating the cases, and discussing the anatomy of the arteries supplying the posterior pharyngeal wall, the author concludes that the pulsating arteries in his cases were the ascending pharyngeal. He then points out the surgical importance of such cases, as, for instance, in incising a retro-pharyngeal abscess. He advises examination with the finger prior to any operative procedure, and suggests that many cases of hæmorrhage after tonsillotomy may be due to the wounding of abnormally large arteries.

**SANDS, H. B.**—Cicatricial Stricture of Œsophagus. *New York Med. Rec.*, January 22, 1887.

A NUMBER of operations of internal œsophagotomy had been performed in 1883 with entire relief of dysphagia. A No. 40 F could then be easily passed, whereas filiform size only could be introduced previously. Between May, 1885, and October, 1886, no instrument had been used, and at the end of that time a 40 could be passed easily. The calibre of the œsophagus still permitted passage of a No. 40, and no difficulty was experienced in swallowing solids.

**EGEBERG, Th.** (Christiania).—Corpus Alienum Œsophagi; Œsophagotomia. *Tidsskrift for Praktisk Medicin*, April 1, 1887.

THE patient, a boy aged ten, had two years previously contracted a stricture of the gullet from drinking lye. After having swallowed a plum-stone, the swallowing even of water had become impossible, and a bougie could not be passed into the stomach, but was stopped 26 centimètres from the front teeth. After several vain attempts to extract or push down the stone with instruments, œsophagotomy was performed about thirty-six hours after the accident. An elastic bougie was introduced into the gullet, and the stone was easily found and removed. A little milk was given the next day, and three days after the operation the patient was allowed to take liquid food

liberally. The twelfth day the external wound was healed, and the patient could swallow solid food. There was no fever after the operation. The patient had once before swallowed a plum-stone, which had passed through after having entirely obstructed the gullet for twenty-four hours.

HOLGER MYGIND.

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## NOSE AND NASO-PHARYNX.

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**MOURE, E. J.** (Bordeaux).—**Considerations on Dry or Atrophic Pharyngitis.** *Rev. Mens. de Laryngologie*, April, 1887.

SOME authors have considered "atrophic" pharyngitis as a symptom of chronic pharyngitis, simple or glandular (Chomel, Laseque, de Mussy, de Tralsh, Morell Mackenzie); others, as a manifestation of the scrofulous diathesis (Isambert, Justin, Lemaistre), or of diabetes (Joal), of fatty degeneration of the heart (Löri); others, again, describe it as a special affection (Lewin, Fraenkel, Solis Cohen, Bosworth, etc.). Dryness of the pharynx, in fact, exists in many general conditions, and in many cases of inflammation of the pharyngeal wall. Moure thinks that the pharyngeal affection is 'oftenest secondary, and the consequence of an atrophic coryza (ozæna); the atrophy of the pharynx is secondary to the atrophy of the nasal mucosa. The author proceeds to study the etiology and symptomatology of the affection.

JOAL.

**BARATOUX.**—**Treatment of Ozæna by Animal Grafting.** *Prog. Méd.*, April, 1887.

IN a research upon "Animal Grafting with the Skin of the Frog, in Losses of Cutaneous and Mucous Substance," undertaken along with Dr. Dubousquet-Laborderie, Baratoux publishes observations upon ozæna, atrophic rhinitis with ulcerations, in which he obtained a complete cure by engrafting the skin of the frog over the ulcerated surfaces. He has thus treated eleven patients having ozæna and ulcerative non-specific rhinitis. In all these subjects he has employed ten to twenty grafts, of which more than half have succeeded, and all the patients have derived much benefit from the treatment. He has always succeeded in obtaining a smooth mucous membrane. He takes the frog's skin from the interdigital membrane, the nictitating membrane, the belly, or the lateral parts, by scissors, and places upon the raw surface with forceps, or a special pipette (by blowing through the free extremity).

JOAL.

**LUC.**—Hereditary Asthma accompanied with Lesions of the Nasal Mucous Membrane. Considerable Amelioration produced by the Local Treatment. *Journal de Médecine, Paris, April 10, 1887.*

A NEW case to be added to those establishing a relation between asthma and nasal catarrh. The patient was twenty-three years of age; the asthma was hereditary and had lasted since infancy, without any hypertrophic condition in the nose. Nasal hypertrophy subsequently developed and led to dyspnoeic attacks. That this was so is demonstrated by the fact that the asthma disappeared after the treatment of the nasal catarrh by the galvano-cautery. JOAL.

**CHEATHAM, W.** (Louisville).—Nasal Reflexes as a Cause of Diseases of the Eye. *Amer. Practitioner, April 2, 1887.*

THE author relates three cases of nasal conditions producing pain in the eyes with weak sight. Two of them were due to nasal polypi, and a third to nasal obstruction from engorgement of the inferior turbinated bone, and deflection of the septum. With the removal of these conditions the ocular troubles were cured. Two cases of œdema of the lids and conjunctiva, with great discomfort in and about the eyes, are referred to by Dr. Cheatham as produced by application of chromic acid to the nasal mucous membrane—all patients complain of pain in the eyes when chromic acid is applied to the nose. He meets daily with cases of conjunctivitis and keratitis (the phlyctenular form especially) which do not yield to treatment until after an existing nasal catarrh or eczema of the nose is cured. Certain cases of glaucoma have been relieved by stretching the nasal branch of the fifth nerve, and these cases might not improbably be the result of chronic nasal disease. Watery and photophobic eyes constantly accompany sneezing. Eye affections may result from diseased and irritable teeth, and Dr. Cheatham has lately had two cases of acute conjunctivitis produced by teething. The author traces all these affections to a connection with Meckel's ganglion, which brings into close connection the nerve supply of the eye-ball and nose.

It is in the anterior part of the nose that the offending lesion must be chiefly looked for. The author thinks that many cases of asthenopia will be cured by attention directed to the nose.

**CALMETTES and CHATELLIER.**—Fibro-sarcoma of the Nasal Septum. Operation. Cure. Histological Examination. *Ann. des Mal. du Larynx, March, 1887.*

A CLASSICAL case, which agrees with those already published, and

which shows that nasal tumours arise oftenest from the cartilaginous septum, are most frequent in women, and are always indicated by epistaxis. Along with Morell Mackenzie, the authors make reservation as to the gravity of the prognosis of carcinomatous and sarcomatous tumours of the nose, though such is generally admitted. The authors believe they have recorded a case of "malignant" tumour with a course, except for epistaxis, as innocent as that of mucous polypi.

The patient often suffered from epistaxis. The tumour was of the size of a cherry, and situated at the anterior part of the nasal fossa at the level of the middle meatus. A detailed histological examination is described.

JOAL.

**MEYERSON.**—Complete Membranous Occlusion of the Naso-Pharyngeal Orifices. *Medycyna*, Nos. 8 and 9, 1887.

THE patient was a woman of thirty-seven. She complained of a continual dryness in the throat and inability to respire through the nose. The author found the naso-pharyngeal orifices completely closed by a thin membrane, which was joined in all its extent to the mucous membrane covering the posterior wall of the arch of the palate, and the pharyngeal roof. By posterior rhinoscopy it was impossible to see the posterior choanæ or the orifices of the Eustachian tubes. Everywhere appeared a smooth and equal surface. The patient breathed only by the mouth. There was nothing abnormal in the nose, and catheterism of the Eustachian tubes was perfectly easy by the ordinary method. The author, introducing a galvano-cautery point through the nose, made a round opening in the membrane, which he afterwards dilated during several days by the introduction of elastic bougies. Passing his finger through the mouth into this opening, he was then able to detach the membrane throughout all its extent from the adjacent structures. The patient has remained perfectly well, respire easily by the mouth, and no longer complains of dryness of the throat. It appears to have been a congenital abnormality.

CONST. KARWOWSKI.

**PLUYETTE.**—Naso-Pharyngeal Fibromata in Women. *Rev. de Chir.*, March 10, 1887.

THE immunity from this condition enjoyed by the female sex is exceedingly curious. Are women really as privileged in this respect as is commonly taught? and can this immunity, be it relative or absolute, be explained by the rules of modern physiology?

The author can only find nine observations recorded of these



tumours in women. Still they are very rare. Starting from the principle that the aptitude to produce fibrous tissue is a property of the individual, Pluyette suggests that menstruation plays the rôle of a continuous revulsion, diverting the production of the basilar apophysis to direct it towards the uterine walls, from whence it would result that uterine fibroma in the female is the analogue of naso-pharyngeal fibroma in the male. JOAL.

**COZZOLINO.**—Two very Rare Tumours of the Pharyngo-Nasal and Nasal Cavities; a Fibroma Molluscum of the Post-Nasal Cavities, and a Papilloma of the Right Nasal Cavity. *Napoli*, 1887.

THAT papillomata of the nose are not very rare is generally acknowledged; and any one seeing many cases of nose disease can recall analogous cases. The case referred to as one of fibroma molluscum was an enormous growth, which the narrator had occasion to see only once, as the patient applied subsequently to Cozzolino. But it would have been preferable, in order to prevent recurrence, to apply a galvanic wire through the anterior nares, as the narrator proposed to the patient, rather than to remove the growth partially with the rigid wire, through the mouth, as was adopted by Cozzolino.

MASSEI.

**SANDS, H. B.**—Naso-Pharyngeal Polypus. *New York Med. Journal*, January, 1887.

PHARYNGEAL examination showed a round smooth mass pendant from the posterior nares, and projecting into the upper part of the pharynx, slightly visible beneath the free border of the soft palate when the mouth was well opened. It was soft and compressible, and probably arose from the front of the foramen lacerum medium. The growth was not seen from the anterior nares. The growth was removed by the galvano-cautery loop, a copper wire being introduced through the left nostril into the mouth; to the end of this a platinum wire was connected and passed back again, being brought out of the left nostril. It was then adjusted about the polypus and drawn tight, the free ends being passed through the handle of a galvano-cautery, which was pressed as far as possible through the left nostril towards the posterior nares. The polypus, when removed, was half as large as an egg. It proved microscopically to be a polypoid fibroma. Very few cases of naso-pharyngeal polypus are suitable for removal by the galvano-cautery, being mostly attached to the skull by a broad base which a wire would not encircle.



## LARYNX.

**FERGUSON, E. D. (Troy).—An Accident in Intubation of the Larynx.** *New York Med. Journal*, March 5, 1887.

THE tube had been introduced into the larynx of a child of three, suffering from diphtheria. Expiration being obstructed, it had to be withdrawn. Expiration remained still obstructed, and it was concluded that the tube had detached and pushed down a piece of false membrane, which acted as a valve, occluding the subglottic space, and tracheotomy was performed. Prompt relief was afforded, but death occurred thirty hours after the operation.

**JUSTO, B.—Penetrating Wound of the Larynx.** *Revista Médica de Sevilla*, Enero 15, 1887.

THE author relates in the *Revista Argentina de Ciencias Médicas* the case of a patient admitted into the hospital at Buenos Ayres with a wound in the anterior part of the neck, extending transversely and somewhat obliquely downwards, and presenting two portions, viz., a deep one on the right side, 5 centimetres long, and a shallow one on the left side of 12 centimetres in length. The lips of the former being 3 centimetres apart, allowed the superior border of the thyroid cartilage to be seen, and over it there was a large opening permitting the free passage of air. The superficial part was sutured, and the deep portion of the wound healed under the Listerian dressing, the patient's head being maintained in flexion. At the end of forty days this extensive wound was completely healed.

RAMON DE LA SOTA Y LASTRA.

**LIEGEOIS.—Epithelioma of the Larynx and Pharynx treated by Tincture of Thuja.** *Bullet. Méd. des Vosges*, January, 1887.

A WOMAN of fifty-four had extensive epithelioma of the larynx and pharynx. The cancerous surfaces were brushed with tincture of thuja occidentalis every two days, and the same drug was administered internally in doses of 10 to 15 drops. Under this treatment there was rapid shrinking of the epitheliomatous nodules occupying the palatine arch, the pharynx, and the tonsils. There was none of the repulsive odour of cancer. The laryngeal epithelioma remained stationary for twenty-six months. The treatment would therefore seem to prolong the life of the patient.

JOAL.

**SCHROETTER (Vienna).—Operation for a Rare Laryngeal Polypus.** *Monats. für Ohrenheilk.*, No. 3, 1887.

THE patient, sixty-one years old, had suffered from hoarseness for five

years ; she had also dyspnœa during her work, and also upon lying on her back at nights. She also experienced a feeling of something moving up and down in the larynx ; at times she had suffocative attacks which ceased with a cough. The laryngoscope revealed the presence of a polypus about the size of a cherry, which during expiration rested over the glottis, but during inspiration disappeared through the glottis. Cocaine being applied, the polypus was removed by the galvano-caustic wire, after having first been fixed with the laryngeal forceps to prevent its being carried into the trachea. Microscopically it was shown to be a fibroma containing much adenoid tissue. After the operation the voice was still somewhat hoarse.

MICHAEL.

**ARIZA, RAFAEL.—A Large Teleangiectatic Laryngeal Papilloma.**

*Rev. de Laryng. Otol. y Rinol., February, 1887.*

AN old woman presented herself to Ariza with aphonia and dyspnœa. A large hypertrophy was observed on the left vocal band, having a rough and granular surface, and being of redder colour than normal. The glottis was very narrow longitudinally, but presenting sufficient space for free respiration. On touching the tumour the patient had a severe attack of apnœa, from which she recovered with difficulty, and during which she coughed much blood. The spot touched exhibited afterwards a depression of about the size of a lentil, from the base of which some blood oozed up. The same phenomena were repeated when at a second sitting the forceps were only passed beyond the epiglottis, the diseased part not being even touched. The attack subsided with the coughing of a small quantity of blood. The patient experienced a third attack of suffocation, but to a less degree, and this time it did not recur, in consequence of the diminution in size of the tumour, and the more open condition of the glottis. With the removal of a portion of the papilloma, of the size of a barley-corn, there was a little bleeding, and, to the astonishment of those who afterwards saw the case, the tumour had entirely disappeared, and the left ventricular band appeared quite normal in size and shape. The cure has been permanent.

RAMON DE LA SOTA Y LASTRA.

**LORETA.—On Instrumental Divulsion of the Vocal Cords in a Case of Laryngeal Stenosis.** *Bullettino delle Scienze Mediche Bologna, December, 1886.*

PROF. LORETA, a well-known Italian surgeon, has published under the above title an article, which, although affording a certain amount of interest, contains considerable material for criticism.

The patient, syphilitic, had alarming dyspnoea. A diagnosis was made of sclerosis of the vocal cords, as the result of syphilitic ulceration. Crico-thyrotomy was performed, and then divulsion of the cords effected by introducing through the incision a common dilator with two branches, like that used for cystotomy. A tracheal canula was then introduced. The improvement was considerable. On the third day the tube was removed, and a large elastic catheter introduced from below till it issued from the glottis. The calibre of the catheter was daily increased; and twelve days after operation the tracheal tube was finally removed. Soon the voice began to improve, and was ultimately completely restored. There was no rise of temperature. The atmosphere of the room was kept moist with steam. The separation of the alæ of the thyroid cartilage appears to demand no further surgical steps for the practice of dilatation. The complete recovery of voice in so short a time is remarkable; and the results justify our asking whether any laryngoscopic examination was made, and the diagnosis thereby verified.

MASSEI.

**DONALDSON, FRANK, JUN.—Paralysis of the Lateral Adductor Muscle of the Larynx—a Unique Case.** *New York Medical Journal*, February 12, 1887.

In this case laryngoscopic examination revealed extreme abduction of the left cord, which was immobile during respiration and phonation. The arytenoids were healthy, nor was there any history that could suggest ankylosis from perichondritis of the arytenoids. An attack of severe pain behind the ear, with the deafness and loss of voice which followed, pointed to a brain lesion as the cause of the trouble. The author then proceeds to discuss the two main theories as to why, both in central and peripheral nerve-lesions, the *abductors* are almost invariably affected; and to summarize Semon's hypothesis of natural proclivity in the abductor fibres to disease, and that of Krause, who holds that atrophy of the dilating muscle is attributable to its mechanical, not to its paralytic, immobility. Next, the author refers to his experiments, and those of Semon and Horsley. He says he is forced to agree with Semon that those cases where the vocal cord is fixed in the middle line are true paralysis of the abductor muscle, and not spasm of the adductor; and, moreover, that the constant implication of the abductor muscle may be explained on the ground of the greater irritability of the abductor muscle or nerve-fibres. Finally, he asserts that his experiments tend to confirm Semon's conclusion.

**OTT.—A Case of Glottic Paralysis with Paresis of Sensibility.**  
*Präg. Med. Woch.,* No. 13, 1887.

IN a case of paralysis of the left abductor, the left side of the mucous membrane was also anæsthetic to the touch of the laryngeal probe, and to electric irritation.

MICHAEL.

**GOUGENHEIM.—The Local Treatment of Laryngeal Phthisis.**  
*Revue Générale de Clinique et Thérapeutique,* March 24, 1887.

LARYNGEAL phthisis, contrary to the opinion of Krishaber, is susceptible of amelioration, and even of cure. To relieve the pain and dysphagia, the author employs cocaine (not in the spray, since this deadens the whole pharyngo-buccal mucosa, and removes the appetite). For tubercular ulcerations he uses iodoform and lactic acid; when the ulcers are seated on a thickened base, the application of these medicaments should be preceded by pretty deep scarifications. M. Gougenheim no longer speaks of the good effect of the galvano-cautery, which he formerly so much vaunted.

JOAL.

**ASTIER, Ch.—The Treatment of Laryngeal Phthisis.** *Baillière, Paris,* April, 1887.

THE author believes (1) in the possibility of retarding, for a longer or shorter time, the formation of tubercular ulcers in a larynx so threatened, when the patient presents at first only a suspicious laryngitis: (2) in the possibility of obtaining cicatrization of a tubercular ulcer; but he adds, that he dare not affirm a definite cure.

During the period which precedes ulceration, Astier recommends emollient inhalations and sprays, applications of a mild solution of chloride of zinc; cauterizations with 20 per cent. nitrate of silver if there is œdema, and employment of the galvano-cautery.

During the period of ulceration it is necessary—(1) to relieve the pains by cocaine, morphia, or belladonna, with inhalation, spray, brush applications, or powders; (2) to treat the ulcers by application of iodine, “liqueur de Vilatte,” galvano-cautery, or iodoform. The author is an advocate of preventive tracheotomy.

JOAL.

**WROBLEWSKI.—Three Cases of Complete Cicatrization of Phthical Ulcerations of the Larynx.** *Medycyna,* No. 11, 1887.

1. A PATIENT eighteen years of age. Advanced phthisis of the lungs, bacilli in the sputa, ulceration of the free edges of the true vocal cords, infiltration and deep ulcerations of the posterior wall of the larynx. Treatment: Frictions with lactic acid daily,

in strength 25 per cent. up to 100 per cent., preceded by cocaineization. Complete cicatrization of the ulcers after ten frictions applied during three weeks. Six months afterwards the patient returned with fresh ulcers and more advanced pulmonary phthisis.

2. A patient forty years old. Advanced hereditary phthisis. Ulceration of the left vocal cord and of the posterior wall of the larynx. Complete cicatrization at the end of three weeks under application of lactic acid of 25 per cent. up to 100 per cent. An excrescence of the shape of a strawberry remained on the posterior wall of the larynx, which was removed by means of a curette, and cicatrization followed in five days. The patient returned six months after with the submaxillary glands of both sides tumefied. The larynx and pulmonary condition remained stationary. The tumefied glands suppurated, and the patient submitted to surgical treatment.

3. A patient thirty-five years old. Syphilitic antecedents. Extensive ulceration of the epiglottis and larynx with advanced phthisis of the lungs and dysphagia. Cicatrizations of the ulcers after fifteen frictions with lactic acid lasting over one month. Disappearance of the dysphagia. Six weeks after, the cure persisted, and the general condition was ameliorated.

The author maintains that it is necessary to use energetic friction even until the appearance of blood. Some patients support this treatment very well even without previous applications of cocaine.

CONST. KARWOWSKI.

**SEIFFERT** (Wurzburg).—**Post-mortem Examination of a Case of Laryngeal Tuberculosis.** *Münchener Med. Wochenschrift*, No. 14, 1887.

THE examination of the larynx showed some of the ulcerations to be cicatrized.

MICHAEL.

**CARDONE.**—**Three Cases of Tracheotomy for Syphilitic Affections of the Larynx.** *L'Eco delle Cliniche*, January, 1887.

CARDONE, assistant to the Laryngological Clinic of Naples, relates three cases occurring among Massei's out-patients. The first was a subglottic gumma operated on by Massei; the second, a considerable infiltration of the whole cavity, the epiglottis being largely involved, so that it looked like a malignant growth,—operated on by Prof. Gallozzi; in the third the affection was localized on the vocal cords,—operated on by Prof. d'Antona. The too hurried removal of the canula necessitated a second operation. The remarks on the manner in which stenosis necessitated tracheotomy, are concisely expressed and much to the point.

MASSEI.



**LEWIS, CHRISTOPHER** (Birmingham).—**Clinical Observations on Syphilis of the Larynx.** *Birmingham Medical Review*, March, 1887.

THE author refers to a case of "relapsing ulcerative laryngitis," which proved to him "how necessary it was to destroy every vestige of a vegetation to ensure against a recurrence of the growth"; and another case of acquired syphilis in a child of eight, in whom there was aphonia, paralysis of the right vocal cord, with little or no abduction, and partially the same condition in the left cord. This was a case of syphilitic aphonia, which recovered under treatment. He also describes a case occurring in a syphilitic man of forty-nine, of cadaveric position of the left cord, and partial paresis of the right cord, with sudden attacks of unconsciousness which simulated the so-called "laryngeal vertigo."

In cases of doubt between syphilis and tubercle, he indicates the following points of differential diagnosis, viz., the presence of bacilli, the dusky redness of the laryngeal cavity in syphilis as compared with the anæmic general condition of the parts in phthisis ("accompanied with reddening and inflammation at the seat of the disease in syphilis"); the characters of the ulceration, viz., deep, unilateral, and with inflamed areola in syphilis, the thickening of the cords in phthisis, the raucous voice in syphilis, and the presence of vegetations which point to syphilis.

**GOUGENHEIM.**—**Tertiary Syphilitic Laryngitis; Tracheotomy; Wearing of the Canula for Seven Months; Cure.** *Ann. des Mal. du Larynx, &c.*, March, 1887.

THE author records the case of a patient in whom inspiratory stridor and suffocative attacks indicated urgent tracheotomy. All that could be learned was that, having had a catarrh for about two or three weeks, difficulty of respiration had supervened a few days before. A deep circular pharyngeal ulceration, along with ulcerated, tumefied, and deformed epiglottis and similar appearances of the arytenoid region (an entire view of the larynx being impossible), indicated syphilis. In three weeks under antisppecific treatment the larynx became normal. The voice had never been completely lost.

The following points make the case worthy of record :—

1. The limitation of the laryngeal lesion, in spite of absence of all internal treatment for three months—whence, the preservation of the voice. Such cases, untreated, generally proceed to extensive disorganization, and stenosis of the larynx.

2. The case with which the patient bore withdrawal of the canula at the end of seven months, the larynx having returned to the normal. The author has seen a case in which the canula was withdrawn at the end of three years. In this the larynx also retained its normal calibre.

JOAL.

**DE ST. GERMAIN.**—Chloroform and Tracheotomy. Lecture at the Hôpital des Enfants Malades. *Bullet. Méd., April 6, 1887.*

*À propos* of the discussion at the Société de Chirurgie (see this Journal, p. 192), the Professor was astonished to have heard it sustained that the employment of chloroform in tracheotomy was common in Switzerland, America, England, Germany, and was sometimes used in certain French hospitals. "I have seen the time when the application of chloroform to tracheotomy seemed likely to surpass its use as an anæsthetic in surgery. I have done 402 tracheotomies, of which nineteen were in the adult, and I have given chloroform more than 13,000 times myself; this is due to the fact that I have no fears about it. As to administering it in tracheotomy, I have never done it or seen it done. Should I do it henceforth? In the adult there is absolute quiet during the operation, especially when practised with a bistoury. This operation is less painful than drawing a tooth, or the opening of an abscess. Chloroform is, therefore, no great help. In children, it is proved that there is no need to operate early—one must wait until the commencement of the period of asphyxia; it is well known that at this moment the child is absolutely anæsthetic, and in this case there is therefore no benefit in chloroform. When, on the contrary, one operates upon a child not as yet asphyxiated, with sensibility preserved, and defending itself against operative interference, chloroform would appear to be of great service; but then it is necessary to practise tracheotomy by Trousseau's method, that is the only one permitting of largely exposing the trachea, and of delaying the incision into it until the wound is no longer bleeding. One must then keep one's self from operating 'en un seul temps.'" De St. Germain shares the views of M. le Dentu, and thinks he set them forth, at the Société de Chirurgie, with wisdom and moderation.

JOAL.

**ROSENTHAL** (Berlin).—Tracheotomies in the Charité Children's Hospital. *Charité Annalen, 1885.*

AFTER eliminating twenty-five children under two years of age, there were, out of 128 cases, 20.4 per cent. of cures for croup, and 18.75 per cent. of cures for diphtheria. It is not necessary to perform the operation after the first attack of asphyxia.

MICHAEL.

## NECK, &c.

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**BRUNEAU.**—**Tubercular Ulcers of the Mouth.** *Thèse, Paris, 1887.*

THE author publishes four observations on tubercular ulcers of the mouth, and criticising the observations hitherto published on the subject, he studies the pathological anatomy, etiology, symptomatology, diagnosis, and treatment of these lesions. It is a good *résumé* of the subject. JOAL.

**Throat Symptoms produced by Hypertrophied Gland Tissue at the Base of the Tongue.** *New York Med. Journ., February 19, 1887.*

THIS is a leading article discussing Dr. H. L. Swain's (New Haven) recent studies on the subject. The disease consists in a hypertrophy of the glands situated between the circumvallate papillæ and the glosso-epiglottidean sinuses, having a lymphatic structure analogous to that of the tonsils. They may become large enough to conceal the epiglottis. The patient complains of a lump in the throat, sometimes of actual pain, and of voice-fatigue. Painting the affected surface with Lugol's solution is all the treatment that is required.

**BÖCHER, CARL** (Yægerspris, Denmark).—**Lingua Nigra.** *Hospitals-tidende, March 9, 1887.*

THE author has observed two cases of this rare disease in two healthy countrywomen, aged between fifty and seventy. In the one case the black patch was about the size of a shilling, and situated in the middle of the tongue in front of the papillæ circumvallatæ; while, in the other case, the patch, which was a little smaller than a halfpenny-piece, was situated on the left of the mid-line, but also in front of the papillæ circumvallatæ, opposite to a decayed tooth. In the latter case the patch was surrounded by a ring of a dirty yellow colour, and on the opposite side of the tongue, corresponding to the black patch, there was a spot of the same dirty yellow colour. In both cases the black patches consisted of soft, brown (at their edges more grey), hair-like vegetations, which were about eight millimetres long and very adherent. The hair-like elongations were seen under the microscope to be the pigmentated proliferations of the epithelial cells, covering the papillæ filiformes, which were covered with a granular mass containing a few threads and numerous spores. The author considers these micro-organisms to be the cause of the disease.

HOLGER MYGIND.

**SCHECH** (Munich).—**The Black Tongue.** *Münchener Med. Wochens.*, No. 14, 1887.

THIS condition is a black-brown discolouration of the tongue, not produced by the ingestion of colouring matter. The condition gives rise to no subjective symptoms, and is often only discovered by accident, or in the course of examination of the patient for other complaints. Schech relates the following case observed by him. A man, thirty-two years old, occasionally presenting another condition of the tongue, exhibited the following peculiarity: On the back of the tongue, commencing with a large area at the base and over the region of the taste papillæ, and thence diminishing to both sides of the raphé, was an intense dark discolouration. The surface of the black parts, which was raised above the level of the normal parts, resembled the nap of a black silk hat rubbed up the wrong way. This caused the raphé to appear more deeply situated than normal. On the surface were many black threads similar to short hairs. These could not be scraped off with a scalpel, but some of them were cut away with scissors for microscopical examination. This examination showed that the condition was not produced by mycosis, as some authors believe. The hairs in question proved to be excessively hypertrophied, pigmented, and horny filiform papillæ. The rarity of the disease renders it impossible to say anything as to the etiology of the complaint. The duration of the disease is various, but it is impossible to determine this, because the patients do not know how long they have had the condition. It disappears without treatment, sometimes in a month, or may last for years. Recurrences are not known, and treatment is unnecessary. MICHAEL.

**LUC.**—**Fœtid Abscess of the Left Maxillary Sinus, simulating an Ozæna; Opening of the Sinus through the Alveolus; Cure.** *Société Médico-Pratique*, February 28, 1887.

AN observation upon a patient in whom the lesion of the sinus was developed subsequently to the avulsion of the first upper molar tooth of the left side. In this case, as in those reported by Ziem, there was no great swelling of the cheek, but the point of emergence of the suborbital nerve was painful to pressure. The sinus was opened through a dental alveolus, an aromatic injection made, and a small drainage-tube placed in the opening. The cure was rapid. JOAL.

**MONOID and RECAMIER.**—**Epithelioma of the Superior Maxilla.** *Société Anatomique de Paris*, April 8, 1887.

THE patient was a woman of sixty-six. The tumour, which had

appeared four months before, had invaded the alveolar arch. After the operation, it was found that the osseous tissue of the jaw had completely disappeared. At the level of the dental arch were found two carious teeth included in the tumour, one of which (the canine) was completely embedded. It was thought that the tumour had originated round the carious teeth, but microscopical examination showed that it was a lobulated pavement epithelioma, having distinctly a glandular origin. JOAL.

**MORALES, PEREZ.**—Cyst of the Maxillary Sinus. *Gaceta Médica Catalana, Enero 15, 1887.*

A PATIENT, fifteen years of age, presented a hard, round, painless tumour in the left cheek. The nasal septum was deflected to the right side, and the left nasal fossa was very narrow. Other organs were normal. A cyst of the maxillary sinus was diagnosed, from the fact that a discharge of sero-purulent fluid had occurred two months previously from a little opening on a level with the second molar, and scars were still left. The patient was operated upon on January 12, the mucous membrane being anæsthetized by cocaine in preference to ether. After cutting through and separating the soft tissues, a great quantity of fluid was liberated on opening the maxillary sinus. The cavity was then washed out and the hæmorrhage controlled, antiseptic plugs being employed; a drainage-tube was inserted, a few sutures were introduced, and a Listerian dressing applied. The patient was discharged permanently cured on February 3. RAMON DE LA SOTA Y LASTRA.

**LARRIVÉ.**—Parotid Cyst. *Journal de Méd. de Paris, March 20, 1887.*

THE condition gave rise to some difficulty in diagnosis. The author considered the question of its being a ganglionic degeneration, but the condition was old, and the patient's health good. The tumour was elastic and less hard than an enchondroma of this region would be. The possibility of its being an enchondroma was rejected. The diagnosis was uncertain. The tumour was opened and a drainage-tube inserted, but the author thinks that, in partial ablation of the parotid, drainage should as much as possible be avoided, and all endeavours should be made to obtain union by first intention of all the wound. JOAL.

**ALESKA.**—A Curious Case of Sanguineous Expectoration. *Gazeta Lekarska, No. 10, 1887.*

A MAN, twenty-six years old, frequently expectorated blood for three



years, and was considered by many physicians to be suffering from hæmoptysis due to a pulmonary lesion. All treatment directed to the cure of this condition was, however, unsuccessful. Aleska was unable to find anything abnormal either in the lungs or larynx. But while undergoing examination the patient coughed, and spat blood, and Aleska observed on the posterior wall of the pharynx a thin thread running downwards, and coming from higher up in the naso-pharynx. He was, however, unable to detect with accuracy where the blood came from. Suspecting its naso-pharyngeal origin, he ordered nasal irrigations of corrosive sublimate (1 in 6,000). This treatment being followed for six months, the expectorations have completely ceased, and the patient, who was previously very anæmic and enfeebled, has quite recovered strength.

CONST. KARWOWSKI.

**RIBBERT** (Bonn).—The Latest Researches upon the Functions of the Thyroid Gland and upon Myxædema. *Deutsche Med. Woch.*, No. 14, 1887.

A REVIEW of current literature.

MICHAEL.

**BROWN-SÉQUARD**.—On the Divers Effects of Irritation of the Anterior Region of the Neck, and particularly on the Loss of Sensibility, and Sudden Death. *Académie des Sciences*, April 4, 1887.

THE section of the skin in the anterior cervical region in all its extent, but especially in the median line and its neighbourhood, produces a complete analgesia in this zone of skin, either over the whole extent, or at least in the portion which covers the larynx and trachea. If surgeons can perform tracheotomy without pain, it is not only, as is generally believed, due to sensibility being diminished by the asphyxia, but is undoubtedly also due to the fact that the skin incision produces, by inhibition, a loss or diminution of the sensibility. The larynx, trachea, and skin covering them are capable, under the influence of mechanical irritation, of producing cardiac inhibition as well as of respiration and of all cerebral activity. A cough may therefore produce a total loss of consciousness, and cardiac and respiratory syncope. Thus the production of death in individuals submitted to incomplete hanging must be explained by interference with, or hindrance to, passage of air into the respiratory tract.

JOAL.

**CLARKE, T. MITCHELL** (Bristol).—On Graves's Disease, with a Case. *Bristol Medico-Chirurgical Journal*, March, 1887.

THE case in question is considered by the author to be unique.

The whole duration of the case was less than six weeks, and the disease therefore was "acute" Graves's disease. Points of interest were: a large and persistent thymus found at the autopsy, the small size of the liver and the pancreas, the very large thyroid, the disappearance of the exophthalmos after death, and the absence of any lesion in the nervous system. The author thinks that exophthalmos and pulsating goitre, the most prominent clinical features in most cases of Graves's disease, are the least constant if we take the whole number of cases, and that the patient may lose them while retaining the other three chief symptoms; and if in some patients either the exophthalmos or the goitre may be absent, and in some both may disappear, it is certainly open to us to argue that in others they may be absent from the beginning.

The author argues in favour of a central origin of the disease.

[With the author's views generally, and in the view that patients may have all the signs and appearances of Graves's disease without exophthalmos or goitre, *i.e.*, "palpitation, anemia, emaciation, and the minor symptoms generally complained of," the reviewer is quite in agreement.]

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## ASSOCIATION MEETINGS.

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### Medical Society of the State of New York.

EIGHTY-FIRST ANNUAL MEETING, HELD AT ALBANY, FEBRUARY 1, 2, 3, 1887.

*The Correction of the Deformity termed Pug-Nose by a Simple Operation.*—Dr. J. O. ROE, of Rochester, read a paper, in which he said that making the outline of a pug-nose regular by taking away a portion caused the nose to look larger, by rendering it unsymmetrical. The operation consisted in turning back the end of the nose, removing sufficient tissue to correct the deformity, and returning the integument. Malformation due to deformity of the cartilage was corrected by dividing the cartilage and making the patient wear a suitable splint. He had operated in five cases, and the result had been good in all.

*The Relation of Laryngeal to Pulmonary Phthisis: Importance of Local Treatment.*—Dr. C. C. RICE, of New York, read a paper, in which he expressed the opinion that laryngeal disease in connection with pulmonary tuberculosis was not always tubercular. In about 65 per cent. of cases there was characteristic tubercular deposit. In the remaining cases the process was slow, commencing with subacute catarrh, becoming chronic, and finally ulcerative. The disease not being often tubercular, the term tubercular laryngitis was unfortunate.

*Laryngeal Intubation.*—Dr. O'DWYER demonstrated the method of performing the operation. Dr. Jacobi said that thirty years ago he had spoken of Bouchut's method as ridiculous. Two years ago he had expressed doubts as to the success of O'Dwyer's method. He was now convinced of its usefulness.

**La Société Française de Laryngologie**

MET ON APRIL 13, 14, 15, 1887.

The officers of the meeting were :—

GOUGENHEIM	...	...	...	...	President.
GAREL (of Lyons)...	}	...	...	...	Vice-Presidents.
SCHIFFERS (of Liege)					
MOURA-BOUROUILLOU	...	...	...	...	Secretary.
JOAL	...	...	...	...	Assistant Secretary.

The following communications were made :—

1. Observations on Hæmorrhagic Laryngitis, by Dr. GAREL.
2. Treatment of Catarrh of the Maxillary Sinus, by Dr. SCHIFFERS.
3. Some Clinical Considerations on Atrophic Rhinitis, by Dr. NOQUET (Lille).
4. Supplementary Glottides, by Dr. GOUGENHEIM.
5. Classification of the Laryngeal Muscles, by Dr. MOURA.
6. Observations on Indurated Chancre of the Right Nasal Fossa, by Dr. MOURE (Bordeaux).
7. Laryngeal Cysts, by Dr. GAREL.
8. Thyroid Tumour, by Dr. AIGRE (Boulogne.)
9. On Anterior Rhinoscopy, by Dr. CRESSWELL BABER (Brighton).
10. Lymphatics of the Larynx, by Dr. POIRIER (Paris).
11. Total Extirpation of the Larynx, by Dr. CH. FAUVEL (Paris).
12. Nasal Vertigo, by Dr. JOAL (Mont Dore).

We shall at a future time refer to some of these papers in greater detail.

JOAL.

## REPORTS OF SOCIETIES.

### New York Academy of Medicine.

*Meeting, December 30, 1886.*

*Deformities of the Nasal Septum.*—Dr. FRANCKE H. BOSWORTH read a paper, containing the analysis of over 150 cases treated with the saw. This condition was probably the most common cause of catarrhal affections of the upper air-passages. Dr. Bosworth called attention to the fact that in addition to the true deflections there were cases of deformity consisting of a prominent ridge running along sutural lines ; the line of junction between the vomer and the palatal process of the superior maxillary bone ; the junction of the cartilage of the septum and vomer, ending abruptly at the junction of the upper border of the septal cartilage and the vertical plate of the ethmoid ; or along the whole anterior edge of the vomer, including its union with the cartilage of the septum and the vertical plate of the ethmoid. There was no depression on the opposite side. Ordinary deflections of the septum and the above deformities are thought by the author to be due to traumatism ; probably in many the injury occurred in childhood. He described a special form of saw, by the aid of which he could correct all deformities, without suppuration or cicatrization and without pain (cocaine being previously applied). Hæmorrhage was always profuse, but rarely called for plugging. He regarded the primary cause of the naso-pharyngeal catarrh as due to deformity of the septum, causing nasal stenosis and hypertrophic changes in the nasal mucosa, this being started by a chronic hyperemia. Then occurred

mouth-breathing. Dr. Bosworth did not agree that in the so-called naso-pharyngeal catarrh there was increased secretion; he thought there was diminished secretion, with difficulty in clearing the nasal passages and vault of the pharynx of the thickened and sticky secretion. As to there being a pharyngitis, the author had never seen it.

Dr. A. H. SMITH did not agree with the author in regard to diminished nasal secretion in catarrh. He questioned whether septal deformities always arose from traumatism. As to the cure of so-called nasal reflexes by treatment directed to the nose, he knew of some relapses, and thought more time was necessary before pronouncing the patient cured. In some of the worst cases of nasal catarrh he had ever seen, the turbinated bones had been almost swept away, leaving large nostrils.

The PRESIDENT (Dr. Jacobi) said that large nasal passages were not required to admit a sufficient amount of air, and hyperemia of the mucous membrane interfered with the free admission of air, rather than bony obstructions or deviated septa. This was to be overcome by rinsing out the nose with a mild solution of nitric acid (1 in 500).

Dr. BOSWORTH said, in reply, that the test of sufficiently large nasal passages was ability to sleep at night with the mouth closed. As to diminished secretion in chronic catarrh, as much as 12 to 16 ounces was daily secreted in health, and passed into the stomach without the patients knowing it. But when the secretion was changed and unhealthy it did not pass into the fauces, or lodged there and was removed with difficulty.

### Chatham (Canada) Medical and Surgical Society.

*Meeting, March 11, 1887.*

*Fracture of the Trachea.*—Dr. FLEMMING reported a case of this rare condition. The late bloody wars do not give the history of a single case. Out of 460 wounds implicating the neck in the French contingent in the Crimea there was but one case, and out of 147 similar neck wounds in the English contingent there were eight such cases. These cases are fraught with much complexity, from the implication of both respiration and circulation.

In Dr. Flemming's patient the injury to the trachea arose through the impulsion against the trachea of a block of wood ( $3\frac{1}{2}$  feet long and an inch thick), hurled from a driving wheel making 1,400 revolutions per minute. It struck the trachea immediately above the sternum. The fourth, fifth, and sixth rings of the trachea were cut completely off, and the ends separated half an inch. With each forcible expiration quantities of blood and clots were expelled through the lacerated opening. There was a feeling of impending suffocation from large quantities of blood flowing into the lungs, and much exhaustion consequent on the hæmorrhage.

As soon as seen the patient was turned on the side, to prevent entry of blood into the windpipe, and ice applications stopped further hæmorrhage. He was subsequently removed to a room with a temperature of  $50^{\circ}$  and kept moist with steam, the head drawn to the chest and kept there. An ice-bag and oilskin covered the wound. Ergot and pot. brom. were given, and milk and beef-tea diet. Progress was favourable for five days, when a violent hæmorrhage occurred, which ceased only when the patient was almost moribund. The following day another hæmorrhage occurred from the veins, and probably also from the inferior thyroid artery, which was beyond reach. Hot water and ice were of no use, and pressure could not be borne, as it interfered with respiration and prevented the escape of clots from the lungs. Recovery was uninterrupted, and the wound was perfectly healed in six weeks. Though possessed before the accident of a good singing voice, the

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patient has since suffered from diplophonia both in singing and talking, but this is gradually disappearing.—*Can. Med. and Surg. Journal*, April, 1887.

### **Berlin Medical Society.**

*Meeting, December 8, 1886.*

*Discussion on Dr. Lazarus's paper on Asthma* (see this Journal, *antea*).—HERR B. FRAENKEL stated that he was the first, five years before Hack's publication, to draw attention to the relations between diseases of the nose and bronchial asthma. The dyspnoea of patients with cardiac disease could not be viewed as true asthma. It is also possible that asthmatics may acquire cardiac disease, but this is exceptional. The Eustachian tubes cannot be regarded as similar to the bronchi.

*Meeting, January 5, 1887.*

Dr. SCHADEWALD spoke upon his theory of asthma as a trigeminal neurosis. He does not believe that nasal polypi can cause permanent asthma, but they may do so temporarily. The affections of the nose must be treated, but the nervous phenomena must be combated by fumigations of stramonium or belladonna. As to priority, Dr. Schadowald says that he does not concur with any one, since the trigeminal theory has not been put forward by any one but himself.

Dr. LAZARUS answered the different speakers.

*Meeting, March 2, 1887.*

*Empyema of the Antrum of Highmore* (Fränkel).—It is possible to procure an exit for the pus by injection of air, but a spontaneous exit is only possible when the patient is lying down. In the erect position, the exit of pus can only occur if the antrum is so extremely filled that the ostium is under the surface of the pus. Formerly, the author has effected depletion by extracting a tooth; he now employs the method of Mickulicz, viz., opening with a trocar. Under cocaine this operation is painless. As to the etiology of the condition, Dr. Fränkel believes that it is more often due to a diseased tooth than to prolonged nasal catarrh.

Herr KRAUSE believed that the empyema was most frequently caused by an extension of nasal catarrh, as Zuckerkandl's examinations prove. The best method of operation is that of Mickulicz, but the instrument might be more practical. Krause demonstrated a "feathering trocar" for this purpose, and a tube, "à double courant," to remove the pus.

Herr SCHADEWALD remarks that in all cases where there is a purulent fluid on one side of the nose only, empyema of the antrum of Highmore must be suspected.

*Meeting, March 9, 1887.*

*Extirpation of the Thyroid Gland*.—Herr J. WOLF thought it possible that cachexia strumipriva is only caused by unnecessary irritations to the gland. In order to prevent such consequences, he ligatured as few arteries as possible, but controlled the bleeding by methodical compression. He maintained that this method yielded good results.

MICHAEL.

### **Society for Internal Medicine, Berlin.**

*Meeting, January 27, 1887.*

*B. Fränkel on Mogiphony*.—Communication of some cases in which the patients, who were singers or speakers, suddenly felt tired, and could not speak or sing any more. These were neither simulation nor hysteria. The cases are curable by massage of the larynx. Being analogous to mogography, the affection is termed mogiphony.



TOBOLD has treated similar cases with the constant current.

KRAUSE believes that such affections are caused by a false method of singing.

G. LEWIN believes that the affections are caused by a false method of keeping the epiglottis depressed in speaking.

MICHAEL (Hamburg).

### Paris Surgical Society.

*Meeting, March 30, 1887.*

*Tracheotomy under Chloroform.*—M. LE DENTU reported four observations of M. Houzel (of Boulogne-sur-Mer). Chloroform, far from increasing the dyspnoea, in these cases was shown to slow and regulate the breathing, small doses sufficed to anæsthetize the patients already enfeebled, no period of excitation occurred, and there were no after vomitings or nauseas. Houzel concludes from this that chloroform is no more dangerous for tracheotomy than for any other operation, provided that asphyxia is not excessive. In extreme asphyxia sensibility is already sufficiently deadened, and narcosis is not called for. M. le Dentu sees no contra-indication to the administration of chloroform in tracheotomy, provided that the respiratory passages are free, and the patient not in a state of commencing asphyxia. M. le Dentu distinguishes two forms of asphyxia, one purely mechanical, the other spasmodic. In the first form, chloroform, favouring blood-stasis in the lungs, increases the danger; but if the asphyxia be of spasmodic origin, chloroform will of itself be beneficial, by relaxing the spasm. In a case of croup, the first inhalations of chloroform should serve as a criterion as to its further anæsthetic use. If respiration becomes slower and more regular, and cyanosis less, the patient should be put under its influence before operating; if, however, these favourable signs do not appear, it should be dispensed with. In all cases of asphyxia so pronounced that death is to be feared during the operation, chloroform narcosis is absolutely contra-indicated.

M. LUCAS-CHAMPIONNIÈRE had used chloroform narcosis while performing tracheotomy in two cases of asphyxia in adults produced by laryngeal tumours, and each time was struck with the diminution of asphyxia during the first inhalations.

M. TERRIER was astonished to hear that tracheotomy with narcosis was anything new, since it has been methodically performed for a long time in England and America, and at the Hôpital Bichat in M. Gougenheim's clinic.

M. VERNEUIL performed a thyroidotomy in an adult with malignant laryngeal neoplasm, in 1862. In narcosis, at the first few inhalations the respirations were improved. Since then he has frequently used chloroform narcosis for operations about the larynx, and always when there is pain. He abstains from using it when the patient is in a state of torpor or somnolence. It would be of great service if an authoritative statement could be sent out that chloroform narcosis is essential to the performance of tracheotomy, in order to conquer the repugnance in many quarters, and amongst many practitioners, to its use.

M. LÉON LE FORT said that thirty-three years ago, Barthez and his colleagues performed tracheotomies under chloroform. He did not agree that it is indicated in spasmodic forms of asphyxia, since the first period of excitation will augment the spasm, and the patient may succumb under it.

M. BEVER did not agree with the last speaker, and remarked that in three cases of tracheotomy on tetanic patients, chloroform regulated and calmed the respiratory movements. He thinks that it also increases instead of diminishing (as it is generally said to do) cardiac action, by relieving the pain which causes cardiac depression.

M. LE DENTU, in conclusion, said that seven-eighths of practitioners were opposed to chloroforming for tracheotomy, and he could not find a single record of

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tracheotomy under chloroform either in M. Hayem's work or in the most recent dictionaries.

*Meeting, April 7, 1887.*

*Tracheotomy and Chloroformization.*—M. TERRIER made a reply to M. le Dentu's remarks at the former meeting, as to his inability to find records of tracheotomies performed under chloroform. Gougenheim, in 1883, insisted upon it at the Société de Chirurgie; Chassaignac, in 1855, protested against its use; in England it is frequently recommended, and in Germany it is entirely accepted. It is accepted by Duret in his *Thèse d'agrégation* in 1880, and by Passavant in 1883. The employment of chloroform for tracheotomy is, therefore, not any new idea,—  
JOAL.

### **Royal Medical and Chirurgical Society, London.**

*March 8, 1887.*

*On Gouty Parotitis and Gouty Orchitis.* By DR. DEBOUT D'ESTRÉES, of Contrexéville.

THE object of the paper was to fill a *lapsus* in the literature of gout, in so far as this disease affects the glandular system, more especially the parotids.

There are genuine attacks of gout having their seat in the glands and alternating with articular manifestations.

The following case was related:—X—, aged sixty-eight, a well-marked gouty subject, was suddenly attacked with swelling at the angle of the jaw, which resisted ordinary treatment and only disappeared on the invasion of the knee on the opposite side. The second parotid and the other knee were also attacked subsequently. Some little induration of the parotids remained, together with salt taste in the mouth, due probably to the presence of urates in the saliva secreted by these glands. Similar cases by Drs. Garrod and Rotureau were also referred to. These cases were promptly relieved by a tincture of fresh colchicum flowers, 50 drops thrice daily.

The author had only seen two cases of gouty orchitis, which, resisting treatment, subsided spontaneously on the appearance of gout elsewhere. The left testicle is most frequently affected, but not invariably. He had not seen it in both parotid and testicles in the same patient.

### **Metropolitan Counties Branch of the British Medical Association.**

*March 9, 1887.*

*Rhinitis with Spasmodic "Snorting."*—MR. SPENCER WATSON read notes of a case in which a young woman aged twenty-six, after a great mental shock, was seized with spasmodic inspiratory "snorting," very frequently repeated. This soon became uncontrollable, and continued for many months in spite of treatment, the spasm coming on sometimes every half-hour and sometimes every ten minutes during the day, ceasing, however, during sleep. Large doses of bromide were given with temporary good effect; but, on their being discontinued, the "snorting" soon recurred with its original intensity. On rhinoscopic examination, Mr. Watson discovered great thickening of the turbinated bodies, which were partially removed with very good effect. Subsequently, nasal plugs were used, and the nostrils were freely sponged with hazeline. The "snorting" had not recurred since the last operation (in January, 1887); and the smell and taste, which had been much impaired, were now perfect. The general health had also improved.

**South-East Hants Medical Society.***March 16, 1887.*

*Syphilitic Infiltration of Trachea and Lung.*—Dr. WILLIAMS FREEMAN showed a specimen taken from the body of a girl, aged thirteen, with a clear history of congenital syphilis, who was admitted for urgent dyspnoea. The walls of the trachea were nearly uniformly thickened, the calibre being reduced to the size of a crow-quill for about two inches below the cricoid. The walls of the right bronchus and its smaller divisions were similarly but irregularly thickened, so that the whole lung was nearly solid. The pleura was adherent, thickened, tough, and leathery; the liver had an old calcifying gumma; the larynx and other organs were healthy.

*Communication between Trachea and Œsophagus from Pressure of a Silver Tracheotomy-tube.*—Dr. WILLIAMS FREEMAN showed a specimen illustrating this condition. Tracheotomy had been performed on a child, aged two-and-a-half, for scald of glottis. There was a vertical slit the size of a shirt button-hole, through which healthy mucous membrane was continuous from the trachea to the œsophagus corresponding with the end of the silver tube. Perforation occurred on the eighth day after tracheotomy. A Baker's rubber-tube was introduced, and there was no sign of any irritation where its end touched the mucous membrane. Death occurred six weeks after the perforation.

**Clinical Society of London***March 25, 1887.*

*A Form of Glandular Swelling curable by Arsenic.*—Mr. FREDERICK TREVES drew attention to the obscurity that attended both the pathology and the clinical history of certain chronic glandular affections. These affections were covered by such terms as the following: hypertrophy of glands, malignant lymphoma, lymphadenoma, Hodgkin's disease, and lympho-sarcoma. These glandular swellings were considered to be un-inflammatory, had no relation to scrofula or syphilis, and were clearly separated from the gland disorders that attended leukaemia. They possessed the common characters of a slow origin without apparent cause, a slow but progressive growth, and an absence of all inflammatory phenomena. Histologically, there would appear to be no means of distinguishing one of these affections from another. Apart from this, objections might well be raised to the terms "hypertrophy" and "lymphoma." Without limiting himself to any special term, Mr. Treves desired to draw attention to the clinical aspects of a certain form of non-leukaemic gland-enlargement that could be cured by arsenic. The patients were usually past middle age; they presented no peculiar constitutional defect; there was no suggestion of gout, rheumatism, or scrofula; there was no leukaemia. The neck was usually involved. The gland tumours appeared on both sides without disturbances in the periphery. The masses varied in size from a hazel-nut to a duck's egg. They were soft, elastic, homogeneous, movable, painless, and free from tenderness. They showed a disposition to spread without limit. The temperature was normal, and suppuration did not take place. Mr. Treves gave instances of the cure of such cases by the use of arsenic. The drug was given in the form of liq. arsenicalis, commencing with a dose of five minims, and increasing to twenty minims three times a day. The treatment had to be kept up for some months—one to six; the glands wasted, some few suppurated, and in some instances the resulting sinuses healed without further treatment. In cases where the whole neck had been filled with great glandular masses, the tumours had wholly disappeared after a treatment of four to six months.

Some of these cases, at least, would probably be covered by the term "Hodgkin's disease." Mr. Treves concluded by an allusion to Dr. Köbel's paper on the "Treatment of Malignant Growth by Arsenic administered by the Mouth, and also Hypodermically."—Sir DYCE DUCKWORTH said that Mr. Treves had observed that the glands in this class of cases were not apt to suppurate, but in his opinion they not infrequently did so. He recollected that about eight years ago, when the use of arsenic was under discussion, he had used it in such a case hypodermically, but without much benefit. He mentioned that chloride of calcium had been strongly recommended by Dr. W. Begley in the treatment of these cases. He referred Mr. Treves to the writings of Trousseau, Gowers, and Southey on the subject.

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## REVIEW.

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**ZUCKERKANDL** (Graz).—On the Centre of Smell. A Comparative Anatomical Study.<sup>1</sup>

THIS book has scarcely the practical interest of the former works of this well-known anatomist, but is nevertheless of scientific value, and will be read with pleasure. The aim of the work, briefly, is to prove that the imperfectly developed condition of the connective tissue in humans is shown by the extent to which the sense of smell is reduced in man. The proof of this is evident on comparison of the rudimentary human organ with the state of perfection which it attains in many animals.

MICHAEL.

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## OBITUARY.

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**HEINRICH ANDREAS BOECKER.**

ONE of the best of German laryngologists, H. A. Boecker, died on March 31 last, at the early age of forty-six, from a pneumonia. Boecker was a pupil of Bruns, to whom he was laryngological and surgical assistant for a long time. He completed his studies in Vienna in 1873, at the courses of Schroetter and Stoerk, and from thence went to Berlin to practise as a specialist. From this time onwards his career was markedly successful, and he not only made a great practice but a great reputation. During his lifetime he operated upon 340 laryngeal polypi. He wrote many papers, mostly concerning laryngeal surgery, all distinguished by much diligence and sharp criticism. His early death is a great loss to laryngological science.

MICHAEL (Hamburg).

<sup>1</sup> "Ueber das Riechcentrum." Enke, Stuttgart, 1887.



## NOTES.

**The Auer-Welsbach Light.**—Dr. Michael writes as follows :—"In the last number of the *Journal*, I took occasion to reproduce the recommendation of the Auer-Welsbach Incandescent Light by Prof. Bürkner and Prof. Schrötter. I have since made personal trial of the apparatus, and though the light is certainly rather white, I am of opinion that it is not so clear as that given by an Argand lamp. The incandescent cone is easily destroyed, and as each costs 3s. to replace, the illumination is very dear. I must say that I cannot advise its use. It is not at present at all practicable." The editors of this *Journal* have both made use of this light for laryngoscopic work. A great saving is accomplished in the amount of gas consumed, and the heat of such a light is less than that of a gas lamp. The light is white, but the great drawback is the fragility of the incandescent cones, which leads to expense and trouble in their replacement. Neither Dr. Mackenzie nor Dr. Wolfenden have found it superior to the ordinary gas lamp. A device in use at the Throat Hospital, Golden Square, is to paint the inside of the gas lamp with oxide of zinc. This increases the brilliancy and whiteness of ordinary gas light, and makes it quite equal to any other method of illumination.

**A Hint in Dilatation of the Œsophagus.**—In dilating strictures in the upper portion of the Œsophagus, Dr. J. Solis-Cohen finds the passage of instruments much facilitated by forcibly drawing the larynx and trachea forwards between the thumb and fingers of the disengaged hand, at the moment that the obstruction is reached by the dilating instrument.—*Amer. Pract. and News*, April 2, 1887.

**An Iodoform Ointment.**—R Iodoform, ʒss.

Ol. Eucalypt. ʒss.

Ol. Rosæ, ℥xx.

Vaseline, ʒiv.—*Ibid.*

**The International Medical Congress.**—All the chief offices of the Congress are filled now. "The scientific success of the Congress is no longer in doubt." A long list of names is already announced, which "looks sufficiently international, and most of them are pretty well known to students of current medical literature." The Congress will not be able to pay the expenses of foreign delegates, which may perhaps keep some of the prominent ones at home. "All those that come however, will find a hearty American greeting awaiting them, and during Congress week, at all events, the latch-string will hang outside."—*Philadelphia Medical Times*, April, 1887.

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THE  
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VOL. I.

JUNE, 1887.

No. 6.

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TRACHEOTOMY IN CROUP AND  
DIPHTHERIA.

(Continued from page 132.)

WHILE we are of opinion that the use of anæsthetics for the operation is neither necessary nor desirable, since the operation is only painful when cutting through the skin, and the little patient is readily controlled by winding a sheet round him, we must admit that the question is an open one. An interesting discussion on this point at the Société de Chirurgie of Paris (reported in the last number of this Journal) will bring before our readers the chief arguments for and against the procedure. Brown-Séquard has recently called attention to the fact that the section of the skin in the median line of the cervical region produces complete analgesia of this part. There is no doubt that chloroform promotes easy respiration, and certainly frequently facilitates an operation which otherwise would be performed with difficulty. Such an authority as De St. Germain, however, finds no necessity for it. It would seem desirable, perhaps, at any rate to produce local anæsthesia by the ether spray or other means, and the question of general anæsthesia by chloroform or ether is perhaps best left to the judgment of the surgeon. Chloroform narcosis is generally adopted in England and Germany. The best method of operating is that with which the surgeon is most familiar. If Trousseau speaks highly in favour of the slow dissecting method, St. Germain, on the other hand, praises the advantages of the more rapid operation by transfixion. The method of operating by the actual cautery<sup>1</sup> has not found favour, notwithstanding that successful results have been recorded, even in children. No more has the galvanic cautery been adopted.<sup>2</sup> Boeckel,<sup>3</sup> of Strasburg, has recently published

<sup>1</sup> De Saint Germain : *Gaz. Méd. de Paris*, March 7, 1874.

<sup>2</sup> Krishaber : *Surg. Society of Paris*, 1873, Nov. 26.

<sup>3</sup> *Rev. de Chir.*, 1885.

notes of 85 cases of tracheotomy performed by aid of thermo-cautery, in which were 44 cures with 4 deaths. The advocates of this method of operating do not, however, carry it out fully. For instance, Bœckel says that the skin and trachea should be incised with a bistoury. These methods of operation are not without their peculiar dangers, and it is not likely that they will ever find much favour. Some surgeons prefer the "high," others the "low" method of operating. The high operation is generally accepted in England and France as the most suitable for children, unless specially contra-indicated, and the cricoid cartilage is frequently incised. One very important point which should be remembered by the inexperienced operator, is to expose the trachea thoroughly before incising it. The difficulty of introducing the tube, which in unskilful or rough hands leads to many accidents, or even is never accomplished at all,<sup>1</sup> is thereby much lessened. The speedy introduction of the canula into the trachea is a point of vital importance. The immediate complications of the operation are hæmorrhage, which is not usually profuse, and is controlled by pressure, torsion, or ligature of arteries,—indeed the speedy introduction of the tracheotomy tube of itself controls the hæmorrhage—and occlusion of the tube by false membrane, blood, or mucus. This obstruction is usually easily expelled through the canula by coughing, but as it is important to get rid of all the secretion possible, it is advisable to introduce a feather through the canula to excite coughing by tickling the trachea, or to drop a few minims of warm water down the outer tube (the inner one having, of course, been removed) drop by drop, and repeat the titillation. Massei<sup>2</sup> has even found young surgeons attempting to remove the secretion by forceps when this mode of procedure would have amply sufficed. Death has been known to occur from the pushing forward into the trachea of a portion of the thyroid gland by the tracheotomy canula,<sup>3</sup> causing fatal bleeding. False membrane may be pushed forward by the tube so as to occlude it. If the means indicated above do not suffice to remove it, aspiration must be resorted to. It is scarcely necessary to remind the surgeon that he should not do this by means of his own mouth, but by a tracheal aspirator,<sup>4</sup> or at least through a catheter. The aspirator

<sup>1</sup> We have seen a young, nervous surgeon, owing to the neglect of this important precaution, complete the operation and put the patient to bed with the tracheotomy canula lying by the side of the trachea, which it had never entered at all! We have all known of patients dying on the operating table under the prolonged exertions of unskilful operators to insert the tubes.

<sup>2</sup> *Lezione Cliniche sulle Malattie della Gola.* Milano, 1884.

<sup>3</sup> Fock : *Deutsche Klinik*, 1859, No. 23, &c.

<sup>4</sup> Parker, *Tracheotomy*, p. 53, has devised an efficient instrument.

should be kept antiseptic. Lindner<sup>1</sup> suggests the administration of apomorphia hourly as a powerful aid to separation of the false membrane. If this fails the tracheal forceps may be introduced through the canula, and if success is still unattainable the canula must be removed entirely, and the tracheal wound may be kept open by a Golding-Bird's retractor in default of its reintroduction. The treatment of occlusion of the tube may be called for at subsequent periods, and the same methods must be pursued. Copious hæmorrhage into the trachea or occlusion of the bronchus will call for similar treatment. These untoward events will be less likely to discompose the surgeon if he will assure himself that the trachea is as much as possible free from secretion before he introduces the canula, and the most important part of this stage of the operation is to keep the tracheal wound open with a dilator until this is effected, by the introduction and twirling about of a feather in the trachea to loosen membrane and promote its expulsion, as insisted on by Parker.<sup>2</sup> Apparent death is one of the complications of the operation, and artificial respiration should be energetically performed. It is remarkable how many patients can thus be rescued. Indeed, the astonishing results obtained by artificial respiration in apparently desperate cases will convince the practitioner of the necessity of performing tracheotomy in cases which even appear to be utterly hopeless at first sight. The after-treatment of the patient is what mostly determines the success or otherwise of the case. A skilled nurse should always be obtained, able to withdraw and replace the inner tube if this is requisite. The temperature of the room should be kept at 70° F., thorough ventilation be secured, and all unnecessary articles of furniture should be removed. It is important to have the air moist and warm, and for this object the croup-kettle or basins of boiling lime-water should be employed. Concerning the use of lime, Solis Cohen<sup>3</sup> knows nothing so useful in detaching pseudo-membranes from the larynx and trachea, as copious inspirations of the vapours arising from lime in the process of slaking, as suggested by Dr. Geiger, of Drayton, Ohio. He feels assured that in his own hands "the remedy has saved a number of children from the necessity of undergoing the operation. Its action seems altogether mechanical, small particles of lime drying up the edges of the partially detached shreds, so that the watery vapour gets

<sup>1</sup> Lindner: *Ueber die Tracheotomie, &c.*, *Deuts. Zeits. f. Chir.* 17 B., 5 u. 6 Heft.

<sup>2</sup> *Loc. cit.*

<sup>3</sup> *Ashurst's Encyclopædia*, vol. v.

under them and accelerates their separation. A small piece of lime in a pail of water is of no use. Several lumps of lime, the size of a small fist, should be placed in a bucket by the side of the bed. Hot water should be poured on them till they are barely covered. A funnel-shaped hood of newspaper, or a stout paper bag with one corner cutoff should be inserted over the vessel, with the outlet directed towards the patient's mouth." The vapours of lime are thus inhaled. The eyes should be protected. If cough or emesis is excited large quantities of false membrane may thus be expelled. Such inhalation, lasting ten to twelve minutes, is to be repeated every half-hour or oftener. The novel treatment proposed by Watson Cheyne of local application of corrosive sublimate, is described in this Journal.<sup>1</sup> Other authorities prefer solvents, particularly soda and potash, applied as steam sprays and frequently repeated. Iodoform has been insufflated into the trachea.<sup>2</sup> While the inner tube is to be removed every two or three hours for cleansing purposes, the outer tube should not be removed for at least twenty-four hours. Blackening of the silver then indicates an unhealthy condition of the wound, which will have to be treated *secundum artem*. The patient must be fed. During the period of traumatic fever the food should be light, afterwards it should be nutritious, but always such as is easy of digestion—soup, milk, beef-tea, eggs, light meats, and wine. Unfortunately many children after two or three days lose all appetite and refuse nourishment, but in these cases every effort should be made to feed the patient, and as Solis Cohen remarks,<sup>3</sup> "delicacies and confectioneries may be allowed, rather than permit the patient to remain without eating." If mouth-feeding be impossible, as it may be from paralysis of the muscles of deglutition, rectal injections will have to be administered. In such cases feeding by the nasal catheter may become necessary. The child should not be permitted to die from inanition if possible, and rectal feeding or alimentation by the nasal catheter may also obviate the production of pneumonia from the passage of food into the bronchi. "Forced feeding" thus becomes a matter of the greatest importance. Regular alvine evacuations should be obtained, but medicine should not be prematurely given, since diarrhoea and emesis often occur a short time after the operation, especially if the child has already been dosed in efforts to expel the false membrane, as is not unfrequently the case.

The operation is not unfrequently unfavourable from various un-

<sup>1</sup> April, 1887, p. 136.

<sup>2</sup> Shirres: *Lancet*, July 24, 1886.

<sup>3</sup> *Croup in its relation to Tracheotomy*, Philadelphia, 1874, pp. 60, 61.



toward complications. Great secondary hæmorrhage sometimes occurs. Revilliod<sup>1</sup> cites a case in which an abscess in the trachea, produced by the introduction of the canula, communicated with the internal jugular vein, causing the death of the patient on the eleventh day after the operation. Frühwald<sup>2</sup> relates a case of fatal hæmorrhage from the bronchi, sixteen days after tracheotomy. In this case there was an aneurism of the brachio-cephalic artery, which opened into the trachea at the level of the seventh cartilage, and the presence of the canula determined its rupture. The innominate artery<sup>3</sup> has been known to be eroded after a tracheotomy. Infarcts in the lungs and ecchymoses of the bronchial mucous membrane have also been found.<sup>4</sup>

Out of 140 tracheotomies recorded by Birnbaum,<sup>5</sup> alarming hæmorrhage occurred in two. Lindner<sup>6</sup> noted that in two cases in which the thyroid was incised during the operation there was very great hæmorrhage. Henoch<sup>7</sup> has noted as the most frequent causes of death, erysipelas, convulsions, peritonitis, and diphtheria of the stomach. Another complication is emphysema, and there is no doubt that it is more to be feared when the low operation is performed. It is not usually of much importance, and gradually disappears. The subcutaneous emphysema has, however, been known to spread to the mediastinum, and bursting into the serous cavities cause double pneumothorax—one such case, described by Moxon, was followed by death in twenty-four hours.<sup>8</sup> Mediastinitis is a very possible complication of tracheotomy, but is probably, as Beal<sup>9</sup> suggests, less to be feared in cases where the high operation is performed, which, in fact, is the only operation now performed in the children's hospitals of Paris. Atelectasis pulmonum was noted eleven times out of thirty-six post-mortems, pneumothorax once, pulmonary œdema five times, hydrothorax once, abscess of lung once, and croupous pneumonia nine times in Birnbaum's<sup>10</sup> analysis of the tracheotomies performed at Darmstadt. Paresis of the posterior crico-arytenoid muscles has been frequently noticed, and this may be complicated with the tracheal granulomata which have been so much discussed

<sup>1</sup> Revilliod : *Rev. Méd. de la Suisse Romande*, vol. cclxxv., June, 1885.

<sup>2</sup> Frühwald : *Jahr. f. Kinderh.*, xxiii., p. 414.

<sup>3</sup> Guaridinger : *Wien. Med. Blatt*, No. 47, 1881.

<sup>4</sup> Remier : *Jahr. f. Kinderh.*, F. iv., B. x., 1876.

<sup>5</sup> *Arch. f. Klin. Chir.*, B. xxxi., Heft. 2.

<sup>6</sup> *Deuts. Zeit. f. Chir.*, B. xvii., Heft. 5 and 6.

<sup>7</sup> *Charité Annalen*, x., 1885, p. 490.

<sup>8</sup> Fagge : *Principles and Practice of Medicine*, vol. i., p. 936.

<sup>9</sup> *Thèse de Paris*, 1886.

<sup>10</sup> *Loc. cit.*



of late by surgeons. In a case of Kappeler's,<sup>1</sup> in which the development of granuloma hindered the removal of the tube for three weeks, the patient was short-breathed afterwards, owing to paralysis of the abductor muscles.

It is now recognized that prolonged retention of the tracheotomy tube leads to the formation of papillomatous excrescences on the tracheal walls. Ross, in an able article in the *Edinburgh Medical Journal*,<sup>2</sup> collected all the cases which had up to that time been known, and very little can be added to his account of this condition. An analysis of the recorded cases showed that the majority of these granulation polypi occurred in male children, and in most after high tracheotomy, though the canula does not appear to have been retained for longer than a week or ten days. The remarkable statement is credited to Mougeot<sup>3</sup> that very few children in which prolonged retention of the canula is necessary reach their majority. A curious projection of the posterior tracheal wall, from an incurvation of the tracheal cartilages (caused by the insertion of a canula), may be mistaken for these granulations.<sup>4</sup> It is very likely, as suggested by Ross, and later by Lovett,<sup>5</sup> that stenosis may be caused by spasm of the glottis from the entry of cold air into a disused larynx. Cicatricial narrowing of the trachea is not a frequent complication, but is one which has sometimes to be dealt with. Collapse of the trachea has even been noticed,<sup>6</sup> and seems somewhat difficult to account for. The complications immediately above described are such as delay the removal of the canula, which in ordinary cases is accomplished in five to nine days. Henoch<sup>7</sup> has seen some cases in which a cure could only be pronounced at the end of two months, and one case in which fifteen weeks after tracheotomy the patient was still rejecting false membrane through the canula. Müller<sup>8</sup> related a case in which the tube had to be kept in for 203 days.

We have not mentioned pneumonia and diphtheria of the wound as complications, as they are well enough known to the ordinary practitioner. It is not our intention to present to the practitioner a complete account of the operation of tracheotomy, but it has been

<sup>1</sup> *Corresplatt. f. Schweizer Aerzte.*, 1882, No. 22, 23.

<sup>2</sup> *Edin. Med. Jour.*, March, 1883.

<sup>3</sup> *Bull. de la Soc. de Méd.*, April 5, 1881.

<sup>4</sup> Carrie: quoted by Ross.

<sup>5</sup> *Bost. Med. and Surg. Journ.*, No. 3, 1887.

<sup>6</sup> Lovett: *Loc. cit.*

<sup>7</sup> *Loc. cit.*

<sup>8</sup> *Arch. f. Klin. Chir.*, 1871, p. 448.

our wish to bring home to him certain truths. Intubation is yet on trial, and we cannot yet bring it into close comparison with tracheotomy, as a means of dealing with the laryngeal complications of diphtheria and croup. We have already spoken favourably of it.<sup>1</sup> We have placed before the practitioner, for whom these remarks are intended, certain points to which we, in conclusion, again direct attention. These are, that no child should be permitted to die for want of courage in performing the operation, and the manner of operating is of less importance than the practitioner might imagine. He will bear in mind that his responsibility does not end with the performance of tracheotomy. In fact, it is then that it commences, and upon his skill and attention, coupled with that of the attendant with whom he trusts his patient—and the responsibility of the nurse is equal to that of the surgeon—depend the welfare of his patient. He cannot be blamed if the disease advances beyond his control, but he should have an uneasy conscience if he omits to recognize the fact that, when he has entertained the proper moment to operate, and acted with decision, he permits his responsibility to end there. He should have a still more *mauvais quart d'une heure*, if he, from fear or fancied danger, allow the little patient to succumb without the benefit of the doubt which operating will give him.

R. DE LA S.

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## INSTRUMENTS AND THERAPEUTICS.

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**STUBLER, A.** (Lawrence, Mass.).—**Rhigolene and Oil as a Vehicle for Sprays. Preliminary Note.** *Med. News, Phila., April 16, 1887.*

Two drachms of rhigolene (by measure) with six drachms of olive or almond oil, make a mixture which requires no more pressure than water to convert it into a fine and permanent spray. If sprayed into the mouth, with closed lips, the spray issues from the nostrils like a cloud of smoke, and is so permanent that its oil globules may be seen floating in the sunlight for more than thirty minutes. The mixture is unirritating to the most sensitive tissues, and seems in some cases to act as a mild local anæsthetic. It does

<sup>1</sup> This Journal, January, 1887, No. 1.

not catch fire when directed into an uncovered lighted gas jet, and does not produce general anæsthesia, thus being free from the objections attending the use of pure rhigolene. The following drugs are readily soluble:—Balsam of copaiba, oil of cubebs, camphor, eucalyptol, iodine, iodol, iodoform, menthol (crystals), naphthalene (crystals), phenol (crystals), resorcine, ol. sassafras, salol, oil of turpentine, and thymol. Resorcine is insoluble in rhigolene, but dissolves in olive oil to the amount of nearly 8 per cent. The mixture will hold 3 per cent. in solution. Every oil seems to be readily miscible, so that the entire list of essential oils may *à priori* be added to the list. No astringent has been found so far which will dissolve in olive oil or the mixture containing it, but iodo-tannin may be prepared by dissolving as much tannin as a saturated tincture of iodine will hold. This will mix with castor oil in any proportion, and the mixture can be thinned with rhigolene to the desired consistence. Cocaine is insoluble in the olive oil and rhigolene, but, like tannin, makes a perfect solution if first dissolved in alcohol and then mixed with castor oil and rhigolene. The above is a preliminary report of experiments conducted by the author and Mr. John H. Green, and will be followed by further communications on the subject.

J. N. MACKENZIE.

**FILLENBAUM** (Wien).—On Local Cocaine Anæsthesia. *Wiener Med. Wochensch.*, No. 11, 1887.

A COMMUNICATION of some surgical cases in which cocaine was applied by means of injection for local anæsthesia. Very good result was obtained in a case of tracheotomy, in a patient fifty years old, with syphilitic perichondritis. The operation could be executed without pain.

MICHAEL.

**GOUGENHEIM**.—On Cocaine in Diseases of the Larynx. *Société Thérapeutique*, April 27, 1887.

GOUGENHEIM uses weak solutions; 10 per cent. generally suffices, and this should be reduced to 5 per cent. in children, women, and nervous persons. The larynx is less susceptible to the action of the drug than the pharynx and the nose, and anæsthesia is less easily produced. The ease with which the pharynx is anæsthetized, leads to the idea of employing it in phlegmonous angina. A very prompt amelioration is obtained by the use of a solution of 25 per cent. Gougenheim also employs cocaine in amygdalotomy, in whooping cough, in ulcerative affections of the larynx, and in œsophageal stricture.

JOAL.

**ROSENBERG, A.** (Berlin).—**Menthol in the Treatment of Tuberculosis of the Larynx and Lungs.** *Deutsch. Med. Zeit.*, 1887, No. 31.

THE author has applied menthol in solution of 5 to 20 per cent. for inhalation and tracheal injection in eighty cases of tuberculosis. He found improvement in all cases. The medicament is antibacillary as well as analgesic.

MICHAEL.

**STUCKY, J. A., and O. F. BROWN.** **Chromic Acid and Trichloroacetic Acid in the Treatment of Hypertrophies of the Pharyngo-nasal Cavities.** *St. Louis Med. and Surg. Jour.*, 1886, ii., p. 263.

THE article reflects the common experience of specialists in this country, and contains no original observation.

J. N. MACKENZIE.

**PORTEOUS, LINDSAY.**—**The Topical Treatment of Tubercular Phthisis.** *Edin. Med. Journal*, May, 1887.

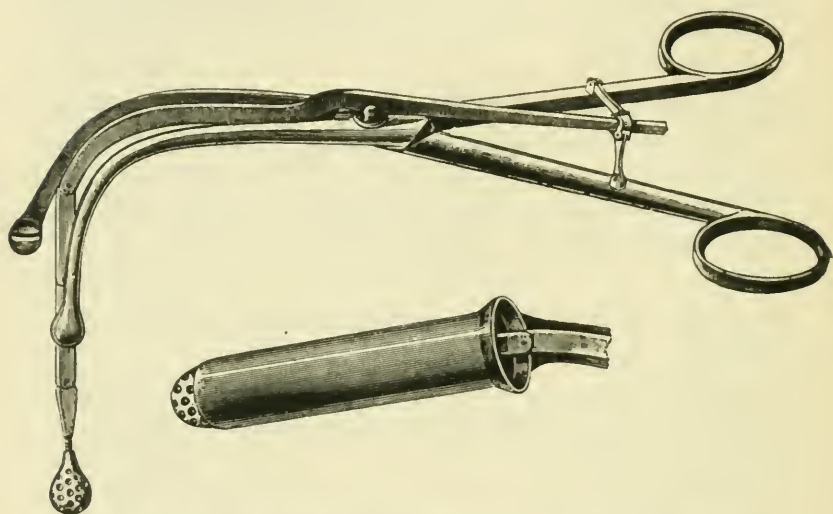
THE remedy recommended is corrosive sublimate: the method, that of spraying. Three illustrative cases are recorded, two of pulmonary, and one, which alone concerns us here, of laryngeal phthisis. The writer concludes his short notice of this case by naïvely stating that "she (the patient) still continues the treatment, and I hope before many weeks are past she will be able for her usual duties."

[It would be difficult to imagine a more unsatisfactory history of a case than that to which reference has now been made. With no record of the examination of the lungs or larynx, or of the sputum, we are gravely invited to believe that an individual "with hoarseness, and whose father and several brothers and sisters had died of phthisis," was suffering from laryngeal phthisis, and that she was recovering under the use of the spray, simply because her voice became clearer, and she was "able to take a short walk!" Both the diagnosis, and consequently the results of treatment, are of a problematical nature. The reporter would take this opportunity of adding that, granted the correctness of diagnosis, he does not believe in the efficacy of the bichloride or any other spray, as a curative agent in laryngeal phthisis. He has, during the last few years, made many observations on the results attained by the use of such sprays, as evidenced by their action upon the bacilli of tubercle, and upon the condition of the larynx, and in no single instance has he witnessed any appreciable benefit from their use, even in such instances where the bichloride was persevered with to such a degree as to induce the constitutional symptoms of mercurialism.] HUNTER MACKENZIE.



**STOERK.**—Intubation of the Larynx. *Wien. Med. Presse*, No. 12, 1887.

AN annotation of Stoerk's paper will be found in the last number of this journal (May, 1887). We now give an illustration of Professor Stoerk's new applicator.



**KILLIAN.**—New Galvano-caustic Battery. *Med. Wochenschr.*, No. 15, 1887.

CHROMIC acid, zinc, and carbon battery. The lowering of the elements into the fluid is executed by the foot, and in this manner the current can be produced and interrupted every moment. This contrivance dispenses with the necessity for any mechanism in the handle for opening and closing the galvanic current. MICHAEL.

**DELSTANCHE** (Bruxelles).—Demonstration of an Apparatus for Replacement of the Nasal Septum. *Achte Jahresversammlung Süddeutscher und Schweizer Ohrenärzte.*

A MODIFICATION of the apparatus devised by Jurasz. MICHAEL.

**HOPE, G. B.**—New Polypus Snare and Amygdalatome. *New York Med. Jour.*, March 19, 1887.

(1) COMBINATION of Jarvis and Schrötter's snares. (2) Physick's instrument with Mackenzie's reversible handle. J. N. MACKENZIE.

**GENESE, D.**—Mirror-topped Syphon Tongue-holder. *Maryland Med. Jour.*, April 16, 1887.

AN ingenious device of more interest to the dental than the throat



surgeon, and to understand which the original matter should be consulted.

J. N. MACKENZIE.

**ROVIRA Y OLIVER** (Barcelona).—**Simple Amygdalitis and Bicarbonate of Soda.** *Gaceta Médica Catalana*, No. 7.

THE author abridges a long essay upon this subject in the following conclusions :—

1. The simple forms of amygdalitis are superficial from the beginning to the end, or superficial in the beginning, but soon advancing until they become parenchymatous ; or, they are deeply seated from the commencement.

2. The anginæ disappear within twenty-four hours by dietetic means.

3. The application of bicarbonate of sodium, over a superficially or deeply-inflamed tonsil, by neutralizing the acidity and retention of the mucus discharged by the follicles, does not fulfil more than a secondary indication.

4. In this manner bicarbonate of soda may expedite the cure of catarrhal and parenchymatous tonsillitis.

5. Bicarbonate of soda cannot be relied upon as an abortive method of treatment of anginæ of the first group.

6. The action of the soda salt is not efficacious in impeding anginæ of the second group—the advance of the catarrhal to the parenchymatous state.

7. When the stroma of the gland has been affected, bicarbonate of soda can produce a cure in from three to seven days.

8. These effects of bicarbonate are attained by making the applications every two or three hours.

9. It is useless, and it may even be dangerous, to apply it, as Dr. Giné recommends, every five minutes.

10. A few styptic drugs, such as sulphate of alumina, are more efficacious than bicarbonate of soda.

RAMON DE LA SOTA.

**ROQUER CASADESÚS** (Barcelona).—**Essay on Bacteriotherapy in the Third Period of Laryngo-pulmonary Tuberculosis.** *Gaceta Médica Catalana*, No. 4, 1886.

THE observations of Cantani, upon the treatment of pulmonary tuberculosis by means of inhalation of *bacterium termo*, induced the author to practise the method in the first case which came under his care. This was a lady with laryngeal tuberculosis in the ulcerative period along with pulmonary cavities. The fluid used was beef-tea with a pure cultivation of *bacterium termo*. Having previously sterilized the bottle containing the fluid, the patient performed

inhalations, and later on her larynx was locally treated twice a day. Only a slight diminution of temperature was obtained; but as the treatment was persevered with for a sufficient number of days without any aggravation of the disease, the author agrees with Dr. Cantani in the opinion that *bacterium termo* is innocent to man.

RAMON DE LA SOTA.

**BASSOLS Y PRIM** (Barcelona).—On Compressed Air in Tuberculosis. *Gaceta Médica Catalana*, No. xxiii., Ano. 80.

USING for two months inhalations of compressed air in the case of a man affected with tubercles in his larynx and lungs, the thoracic affection was cured, without, however, the larynx undergoing the slightest modification. The author studies the effects of inhalations of compressed and rarefied air, and he concludes that the latter must be used at the beginning of tuberculosis, when patients preserve a certain degree of vigour, and the former in tuberculous patients who are attenuated.

RAMON DE LA SOTA.

## DIPHTHERIA.

**GRASSMONT, GILLET DE.**—Observation on Diphtheria transmitted from the Throat to the Eye, and reciprocally. *Journ. de Méd.*, May 8, 1887.

A CHILD, fifteen months of age, was attacked with ocular diphtheria, which was communicated to him by a brother, five years of age, at the time suffering from a diphtheritic angina which ended fatally. The mother in attending to the youngest child (suffering from ocular diphtheria) was herself attacked with a diphtheritic angina. JOAL.

**SCHENKER.**—Treatment of Diphtheria. *Correspondenzblatt für Schweizer Aerzte*, No. 18, 1886.

RECOMMENDATION of the treatment of Delthil and internal use of turpentine.

MICHAEL.

**ENGELMANN.**—On the Antiseptic Effect of Acetic Acid and its Application in the Treatment of Diphtheria. *Centralblatt für Klin. Med.*, 1886, No. 14.

A RECOMMENDATION of the local treatment of diphtheria with acetic acid.

MICHAEL.

**LEWENTAUER** (Constantinople).—The Use of Rectified Oil of Turpentine in Diphtheria and Croup. *Centralblatt für Klin. Med.*, 1887, No. 3.

ONE case treated with turpentine with good result.

MICHAEL.

**BONAMY.**—A New Trial of Vaporizations of Infusion of Eucalyptus in Diphtheria. *Bulletin Thérapeutique*, April 30, 1887.

THE author relates nine cases of diphtheria, of which five were diphtheritic angina, and all cured; four anginas and diphtheritic laryngitis operated upon, with two cures and two deaths. Besides the local application of citron juice to the spots involved, and the administration of chlorate of potash internally, eucalyptus infusion was employed in vapour. Sixty grammes of eucalyptus leaves were added to a litre of boiling water, and the atmosphere of the room so saturated with the vapour that it condensed on the windows. The room temperature should be kept at 18° to 22° C. The author claims that these vapours have a solvent action on the false membrane, the fibrinous exudation appears to dissolve, and the thick adherent membranes are transformed into a yellow deliquum, and are detached with ease on coughing.

JOAL.

**BELTRAN OBIOL** (Valencia).—Treatment of Diphtheria by Helenine. *La Crónica Médica*, 1886.

AFTER relating the clinical history of a few cases of diphtheritic sore throat, the author arrives at the following conclusions:—

1. The treatment of diphtheria by helenine is the most useful, owing to its simplicity and harmlessness.
2. It is also one which succeeds in curing the greatest number of cases.
3. Cauterizations in diphtheria are pernicious.
4. The administration of helenine to diphtheritic patients prevents albuminuria.
5. The diphtheritic sore throat generally appears on the left tonsil.
6. Helenine is one of the most powerful antiseptic agents.
7. The result is dependent upon the period at which the medication is first used. If on the first day of the disease the patients find themselves better, on the next day; but if not begun till the second day, the cure is delayed by two or three days; and six or nine days, if the medicament is not taken until the third or fourth day; finally, if diphtheria is already five or six days old, then helenine sometimes fails.

RAMON DE LA SOTA.

**CAMPÁ** (Valencia).—Clinical Annotations upon Diphtheria. *La Crónica Médica*, 1886.

FROM its infectious nature the author believes that diphtheria is at first only a local disease. He has noticed several ways in which this affection begins:—

- 1st. Fulminant diphtheria. From the first moment there are some

diphtheritic patches upon the tonsils, the pillars of the fauces, and the pharynx ; erythema in the mucous membrane, with tonsillar and sub-maxillary thickenings. In other cases the fauces are healthy, and croupal cough is the first symptom observed ; the diphtheritic patches are suddenly extended to the glottis and vocal cords, and death occurs in a short time.

2nd. Progressive, slow diphtheria. There is a preceding slight fever, which lasts two or three days. At the end of this time a diphtheritic spot appears upon the tonsils or the pillars, and it extends towards the mouth and the choanæ, or towards the larynx. In the latter case croup appears, with all its characteristic symptoms.

3rd. Hidden diphtheria. The symptoms on the first day are merely catarrhal—coryza, bronchitis, little or no fever, cough without special character, swallowing unaffected. The diphtheritic exudation begins in the nasal fossa, and it may very possibly be overlooked if the membranes are not extruded with the discharges. At last the patches extend into the pharynx, and the patient dies without croup, having slowly passed through the periods of the disease.

4th. Insidious form. There are catarrhal symptoms, great thickening of the sub-maxillary and parotid glands, fever of an undetermined character, and chilliness. After remaining a few days in this state, diphtheritic patches appear upon the pharynx ; these extend suddenly into the larynx and trachea, and the patient then succumbs.

The author considers that the free forms are the mildest, and that difference in form depends upon the bodily predisposition of the subject. The size of the patches does not influence the intensity of the general infection. The gravity of this disease depends on the bodily resistance ; and this is subject to the following law of progression : *from two years forwards the predisposition begins to show itself, and keeps increasing up to five years, a period at which it reaches its maximum, diminishing then according to the advancing age of the patient.*

With regard to treatment Campà has already given up strong cauterizations and all other destroying means. Now he limits himself to lime water, to solutions of sulphate of alumina, of boric acid, and corrosive sublimate. If absorption of the diphtheritic poison has not occurred this local treatment is sufficient, but if it has already taken place (evidenced by the thickening of the sub-maxillary glands), we must prescribe general treatment with alcohol, and quinine and iron in a soluble form (phosphate). If the larynx is involved, we must excite expulsion of the diphtheritic membranes by emesis. When, notwithstanding the use of these means, the patient

becomes asphyxiated, we must resort to tracheotomy. Campá accepts it only as a last resort, and without expressing any great enthusiasm for it, he yet believes that we should always perform the operation in diphtheritic croup, in order to relieve respiration embarrassed by laryngo-stenosis, although the operation is not sufficient to avert death if general infection proceeds rapidly, or if the false membranes have already reached the trachea.

RAMON DE LA SOTA.

**RODON FIGUERAS** (Barcelona).—**Treatment of Croup by Calomel in large Doses.** *Gaceta Médica Catalana*, No. xi., Ano. 80.

THE author recommends the administration of 50 centigrammes of calomel every hour, from the first appearance of laryngeal symptoms, since if the treatment is commenced only when the croup has reached the period of asphyxia a cure is not obtained. The hydrargyroses and the hydrohæmia rapidly obtained are factors which impede the formation of croupous exudation, and we attain this poverisation of the blood so completely that the author has been compelled to administer iron during the convalescence of all his patients, in order to attack the anæmia, the swelling of the face, the œdema and petechiæ, the presence of which has never been wanting.

RAMON DE LA SOTA.

**CARBÓ VALLÈS** (Barcelona).—**Differences between Diphtheritic Angina and Croup.** *Revista de Ciencias Médicas*, No. xxiii., Ano.

12.

FROM observations made on 150 patients treated by the author, he concludes that diphtheria and croup differ greatly in their symptoms and their etiology. From this he makes the deduction that the difference of treatment adopted by physicians in each of these affections is quite reasonable.

RAMON DE LA SOTA.

**VALERA Y GIMENEZ** (Barcelona).—**Albumin in Diphtheria.**

*Revista de Laringologia, Otologia y Rinologia*, Marzo y Abril, 1887.

THE author, from his own observations, concludes that albuminuria occurs in all diphtheritic patients, but that the quantity does not correspond to the gravity of the disease; and he considers it as a sign of secondary infection by the diphtheritic germ, which possesses amongst other things the power of separating albuminoid matters from the blood, and causing their excretion, also the property of assimilation, as a consequence of which they are eliminated by the kidneys as foreign bodies.

RAMON DE LA SOTA.



## TONSILS, PHARYNX, &c.

**FEURER** (St. Gallen).—On Tuberculosis of the Tongue. *Correspondenzbl. für Schweizer Aerzte*, No. 16, 1886.

A REPORT of three cases, with clinical remarks. Sometimes it is very difficult to differentiate between tuberculosis and carcinoma, because there are often few bacilli, and tuberculosis sometimes also assumes a tumorous character. Tuberculosis must be treated operatively, just like carcinoma. For generalized tuberculosis the author recommends solution of camphor, 1 : 300, as a gargle.

MICHAEL.

**LONGE** (New York).—Extirpation of Tongue, Floor of Mouth, and Submaxilla, for Cancer. *Med. News*, January 22, 1887.

LONG account of an interesting case.

J. N. MACKENZIE.

**PEYROT**.—Chloroform and Amygdalotomy.

SEE Report of Paris Surgical Society, April 20, 1887. (This Journal, p. 231.)

JOAL.

**COHEN, J. S.**—A Series of three Epithelial or Pseudo-Membranous Casts of the Tonsils and Palatine Folds, from a Case of Diphtheria. *Med. News*, January 22, 1887.

THE point particularly called attention to was the physical resemblance of the patches to the desquamated epidermis in scarlatina.

J. N. MACKENZIE.

**LONGE**.—Sarcoma of Pharynx, Removed by Partial Exsection and Dislocation of the Inferior Maxilla. *Med. News*, March 19, 1887.

OPERATION long and tedious ; recovery with paralysis of lip. After preliminary tracheotomy, an incision was made along the inner border of the sterno-mastoid muscle, and a horizontal one along the border of the zygomatic arch, so as to expose the angle of the jaw which was removed subperiostially, so as to give access to the tumour.

J. N. MACKENZIE.

**POTAIN**.—Œsophageal Stricture of Syphilitic Origin. *Gazette Médicale*, April 23, 1887.

A LECTURE given at the Charité Hospital on the case of a patient who for three or four months had only been able to take liquids or softened bread. A bougie proved the presence of a stricture at the level of the trachea, and considerable pressure was necessary to pass the instrument, excluding the idea of spasm. There could be no

question of congenital or cancerous origin, and as there was motor ocular paralysis, the professor concluded the stricture to be of syphilitic origin. JOAL.

**SYMONDS, CHARTERS J.**—The Treatment of Malignant Stricture of the Œsophagus by Tubage or Permanent Catheterism. *Brit. Med. Jour.*, April 23, 1887.

THREE cases of epithelioma and one of simple stricture are related, with the object of confirming Krishaber's conclusions that tubes can be safely worn for long periods with the effect of prolonging life. The author discusses the short tube, its range of usefulness, the difficulties and accidents attending its employment. Among the latter is the possibility of the tube passing beyond the stricture, and inability to withdraw it. When considerable dilatation has been effected by the short tube, it may be removed altogether from time to time. If cough on swallowing supervenes, Krishaber's long tube must be substituted or gastrostomy performed. The paper is exceedingly instructive. GREVILLE MACDONALD.

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## NOSE AND NASO-PHARYNX.

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**MAYS, T. J.**—The Nasal Reflex. A New Method for Determining the Local Sensory Action of Drugs. A Preliminary Note. *Med. News*, November 20, 1886.

FIVE or six drops of a one or two per cent. solution of the drug to be tested are slowly dropped into one nostril of a good sized frog at intervals of from three to five minutes, and the nasal reflex is tested by introducing the end of a very fine and light wire into the nostril under the influence of the drug, and fill as into the nostril of the opposite side, and the effects compared. The nasal reflex is extremely sensitive and shows the slightest interference with its integrity. Anæsthesia is gradually produced in the drugged nostril, while in the other the sensibility remains intact. This method has been used by the author in determining the difference between theine and caffeine—a sufficient guarantee of its delicacy and accuracy.

J. N. MACKENZIE.

**POHL.**—Observation on the Occurrence of Nasal Respiration before Thoracic and Abdominal Respiration. *Prager Med. Wochenschr.*, No. 16, 1887.

IN three cases, complicated with great respiratory trouble (Morb.

Brightii, Emphysema, Hydrothorax), the author observed that the dyspnœic movements of the nose sometimes preceded the respiratory movements of the thorax and abdomen. The phenomenon could be observed by simple inspection, and exhibited graphically by using Marey's instrument.

MICHAEL.

**VALENTIN.**—On Chronic Coryza and Ozæna. *Correspondenzblatt für schweizer Aerzte*, No. 2, 1887.

A SYMPTOM, not yet recognized, but present in many diseased conditions of the nose, is the failure of the superficial epithelium. By scraping the mucous membrane and making a microscopical examination of the scrapings, it is easy to see if this is absent. In dry catarrh the author recommends the application of solution of saponine, in true ozæna irrigation with salt solution.

MICHAEL.

**NOQUET** (Lille).—Some Considerations on Atrophic Rhinitis. *Rev. Mens. de Laryngologie*, May, 1887.

THE author observed thirteen patients afflicted with this condition. There was no direct evidence of scrofula in any, but while some appeared to be a little lymphatic, many, on the other hand, appeared to be in vigorous health. Syphilis was absent in all the cases. The saddle-shaped nose, on which Zaufal insists, was only met with in one case, and Noquet attributes but little importance to this sign from an etiological point of view. Fætor was especially evident in young subjects under twenty years of age; above that age it was less intense. The pathological process proceeds towards the Eustachian tubes and middle ear; all the patients above twenty years of age came to Noquet for affections of hearing, and were undoubtedly affected with median otitis, the more marked the older they were. In young subjects the post-nasal cavity was encumbered with thick lumps of mucus, in others there were dry crusts on the mucous membrane. Most authors think that it is possible only to palliate atrophic rhinitis, but Noquet's experience leads him to the conviction that a well-directed treatment followed punctually for a long period will be followed by complete cure, and he has been enabled to state a very marked regeneration of the atrophied parts in young subjects. He also agrees with Gottstein in the opinion that atrophy of the mucosa is consecutive to a chronic inflammation, and dismisses the theory of congenital atrophy held by Zaufal, as well as that of Calmettes and Martin, that the condition is due to arrest of development. He rather leans to the opinion of Læwenberg, that atrophic rhinitis is due to the invasion of the nasal cavities by a special diplococcus.

JOAL.

**VERNEUIL.**—Treatment of Obstinate Epistaxis. See Report of Academy of Medicine, April 26, 1887. (This Journal, p. 232.)

JOAL.

**PATRICK, Z. E.**—A Simple Method of Arresting Epistaxis.

*New York Med. Jour.*, March 19, 1887.

A PIECE of bandage is tied across each thigh close to the body, and, if necessary, around each arm, just tight enough to prevent the venous circulation without interfering with the arterial. The hæmorrhage is said to cease almost instantly. The author has used the method often successfully.

J. N. MACKENZIE.

**SCHÄFFER and NASSE.**—Tubercular Tumours of the Nose.

*Deutsch. Med. Wochenschr.*, 1887, No. 15.

THE author has seen eight cases of tubercular tumours of the nose. In all these cases the tumour was seated upon the septum. There were always some tumours of varying size up to the circumference of a nut. The tumours bled easily, and were rather harder in the middle than the outer portions, which were soft. After operation there was always a great inclination to recurrence and to ulceration, and this sometimes caused perforation of the septum. An hereditary predisposition to tuberculosis was present in most cases. The affection always began on the septum. Very energetic local treatment was in all cases combined with a general treatment, but in no case did complete cure follow. The history of six cases as observed by the author is given. Nasse made an anatomical and microscopical examination of the tumours in two cases. In the first the tumour was pyriform and possessed a fibrous stroma in which a great many small and confluent tubercles were seated. Larger portions were cheesy. Tubercle bacilli were not abundant. The second tumour was of a more irregular form, but of the same microscopical characters.

MICHAEL.

**LANGE, V.** (Copenhagen).—Operation for Choanal Polypi. *Deutsch. Med. Wochenschr.*, 1887.

FOR such polypi as are difficult to operate upon by other methods, the author recommends a blunt hook, with which he obtained good results in many cases.

MICHAEL.

**DUFFIELD.**—An Operation for Post-Nasal Sarcomatous Tumour.

*Med. News*, April 23, 1887.

DR. S. P. DUFFIELD writes to the *American Lancet*, of April, 1887, of an operation performed by Dr. Wahl, of Dorpat. Instead of the Mott way of splitting the nose, he made an incision across the nose,

following the line of articulation of the ossa nasi with the os frontis, and then down the right side in the line of articulation with the maxillaris; breaking through the articulation of the os frontis with chisel and mallet, he turned the nose over upon the cheek, and had a good, unobstructed opening through which to work, and with a curette removed the tumour piecemeal, replaced the nose, and fastened with sutures. Two days afterwards the patient's nose looked "as natural almost as ever." J. N. MACKENZIE.

**BENOIT.**—Hay Asthma. *Paris Médical*, March 14, 1887.

AN observation of a patient attacked with dyspnœic phenomena, and having inflammatory affection of the nose. Nothing new.

JOAL.

## LARYNX.

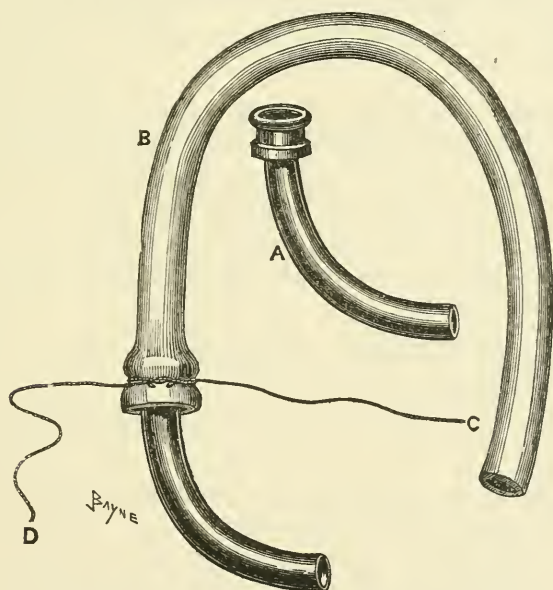
**ANNANDALE**, Prof. (Edinburgh). — Note on Preliminary Tracheotomy as an Aid to Certain Operations. *Edin. Med. Jour.*, March, 1887.

THE writer lays down two important principles of preliminary tracheotomy in certain operations involving the mouth, throat, or jaws:—(1) The prevention of blood passing into and obstructing the air-passages; (2) the security of free and proper respiration, together with the safe and convenient administration of an anæsthetic. He further adds that much blood should not pass down into the stomach, as it may cause vomiting, and so interfere with the operation. He does not believe in the efficiency of Trendelenburg's tampon-canula, or in any of its modifications, and accordingly has devised a special apparatus, which he thus describes:—

"My apparatus, figured in the woodcut, consists of a vulcanite tracheotomy tube (A) which has a broad ring attached to, but moving round its neck, and of a piece of ordinary india-rubber tube about eighteen inches long, and having a diameter of half-an-inch. One end of the india-rubber tube (B) is passed over the ring at the neck of the tracheotomy tube, and secured to it by a piece of strong silk, the ends (D and C) of which are left long. The trachea or larynx having been opened, the tracheal tube is introduced as far as its neck, and then each end of the silk is, by means of a needle, brought through the corresponding edge of the wound of the skin, and when these are tied together they not only retain the tube in the trachea, but also close the external wound, and prevent any blood passing into the trachea in this way. The movable ring round the neck to



the tracheal tube has the advantage that it allows of some corresponding movement of the tubing connected to it, so that the latter is much less liable to be twisted or bent, and its canal to become obstructed. To administer an anæsthetic, the fore-end of the tubing is introduced into a glass or tumbler, in the bottom of which a little cotton wadding is placed, and upon this cotton wadding, chloroform or ether is dropped from time to time, as may be required to keep up the anæsthesia." After the performance of the tracheotomy the throat should be thoroughly stuffed by means of a piece of sponge or some cotton wadding, *covered by oil silk or some other thin waterproof material*, in order to diminish the chance



of any blood oozing through the pad. The tube may be removed immediately after the performance of the major operation, but only if the bleeding have ceased, and there be no risk of swelling or œdema in the neighbourhood of the glottis.

The writer believes that, under the above circumstances, preliminary tracheotomy ought perhaps to be practised more frequently than is the case. He further adds that in three recent cases involving the removal of large and vascular tumours from the mouth and throat, not only was preliminary tracheotomy performed, but also preliminary ligature of the corresponding common carotid artery, and to these measures he attributes much of the success which followed each of the operations.

In the discussion which followed the reading of this paper (before the Medico-Chirurgical Society of Edinburgh, January 19, 1887), Drs. Duncan and Scott-Lang, and Mr. Cathcart took part, and enunciated views which agreed, in the main, with those entertained by the writer of the paper.

HUNTER MACKENZIE.

**NOTA, ANNIBALE.**—Two Tracheotomies. *Gazzetta degli Ospedali*, No. 36.

THE author relates two cases of tracheotomy,—the one, in a girl three years old, for a foreign body in the windpipe; the second, in a child four years old, suffering from croup. Both were successful. Dr. Nota adduces the following conclusions:—(1) that the low operation is preferable; (2) that it is advisable to remove the canula as early as possible.

MASSEI.

**LUC.**—Laryngeal Intubation Applied to the Treatment of Croup and Acute Laryngeal Stenoses. *Bulletin Médical*, May 8, 1887.

A BIBLIOGRAPHIC review. The author concludes that there is a certain number of special cases in which intubation can be advantageously employed, for example, children under three and a half years of age suffering from croup, and in whom tracheotomy is refused by the parents.

JOAL.

**DUBRUEIL, A.**—Intubation of the Larynx. *Gazette Hebdomadaire de Montpellier*, April 2, 1887.

A BIBLIOGRAPHICAL article, containing a review of O'Dwyer's work.

JOAL.

**FERGUSON, E. D.**—An Accident in Intubation of the Larynx. *New York Med. Jour.*, March 5, 1887.

IN a case of diphtheria the O'Dwyer tube became detached, and carried in advance the false membrane, thereby occluding its lower orifice. Tracheotomy was done, and the patient died on the third day.

J. N. MACKENZIE.

**YOUNG, D. S.**—A New Treatment for Incised Wounds of the Throat Penetrating the Air-passages. *Lancet-Clinic.*, March 5, 1887; *Med. News*, April 9, 1887.

AFTER the hæmorrhage is controlled and the injuries to the internal appendages are attended to, he proceeds to close the wound both internally and externally (to render it impervious to air and fluids) by uniting the incision in the windpipe with catgut sutures passed through the cartilage, including the mucous membrane, one-eighth inch apart, firmly tied, and the ligature cut close to the knot. When

the air-passage is completely or extensively divided, two or three silk sutures may be placed, one on each side and one in front, to sustain better the parts in position, as they will not be affected by moisture as the gut is liable to be. The external wound is cleansed, its margins brought together and secured with pins or wire sutures. The head is brought slightly forward, and held by a cap with tapes fastened to a band around the chest. In cases of violent delirium, Christopher's plaster of Paris dressing is invaluable, as it secures rest to the parts and leaves the throat freely exposed. No special dressing is required. The patient speaks and swallows immediately after the wound is closed, but should be restrained. The external sutures may be removed in five or ten days; the internal are allowed to be absorbed or thrown off. No irritation or spasmodic coughing has been excited by their presence.

J. N. MACKENZIE.

**AGNEW, D. HAYES** (Philadelphia).—**Excision of the Larynx and Pharynx.** *Med. News*, April 9, 1887.

TUBULAR epithelioma filling the larynx and also the pharynx to such an extent as to require the entire removal, saving a very narrow strip of its posterior wall. An incision was made from the hyoid bone to the middle of the suprasternal fossa over the median line of the neck, the thyroid isthmus divided between ligatures, the adjacent muscles separated from their insertions and dissected away. The trachea was separated from the œsophagus sufficiently to admit a grooved director, when the former was severed by a probe-pointed bistoury carried between the cricoid and its first ring. A rubber cork, through which was passed a syphon tube, was made to fit accurately in the lumen of the trachea. The larynx was next excised, and the diseased portion of the pharynx. Before the last dressings were made, the secretions ran down in a stream through the wound. Fearing that they might make their way through the loose tracheal tissue to the mediastinum, an aseptic sponge with cord attached was passed through the upper part of the wound into the fauces. The second day following the operation the patient showed signs of exhaustion, and on the third day died. No autopsy was allowed, but death occurred probably from congestion of the lungs and heart failure.

J. N. MACKENZIE.

**GARDNER, W.**—**Excision of the Larynx.** *Lancet*, May 7, 1887.

THE case is the third operated on in the British dominions in which the patient has lived over four months. The disease was cornifying epithelioma, and recurrence was very rapid. The author recommends the use of a rectangular canula, fitting the full diameter of the trachea,

as a preventive of hæmorrhage into the air-passages and of septic pneumonia. He prefers "the hanging head" position. He concludes that Gussenbauer's original artificial larynx is the best.

GREVILLE MACDONALD.

**THORNER** (Cincinnati).—Removal of a Cockle-burr from the Larynx by Voltolini's Sponge Method. *Cincinnati Lancet and Clinic*, 1886, No. 17.

THE nature of the case is sufficiently indicated in the title of the paper.

J. N. MACKENZIE.

**MASSEI**, Prof. F.—On a Case of Laryngeal Papilloma. *Lezione Bollettino*, Anno v., No. 2.

A GIRL of thirteen had complained of hoarseness for a year without other disturbance. Laryngoscopic examination disclosed a little elevation, pale red and movable, situated on the anterior third of the left vocal cord. The rest of the cavity was normal, except that the cords, slightly swollen and reddened from the presence of the tumour, could not approximate during phonation. The mirror explained the aphonia, and removed any doubt as to anatomical diagnosis. The author took the opportunity of illustrating the physiology of voice-formation. Then he passed on to discussing the nature of the tumour. He spoke of papillomata in general, of their frequency, structure, course, recurrence, and rapid growth, but more especially of the age of the patient; and on these points he established the prognosis in general, and of the case in question. As for treatment, the author prefers repeated excision to cauterization. In general one should avoid irritating the growth, while we must remove exuberance of the tumour, and so gain time. In the case in question tracheotomy was performed.

MASSEI.

**FERRERI**, Dr. G.—Treatment of Laryngeal Papillomata. *Lo Sperimentale*, fasc. 2, February, 1887.

THE author insists on the distinction between papillomata and simple granulations. He confirms the opinion of laryngologists as to their frequency, the age of the patients, their situation, &c. As for treatment, the clinic at Rome have desired to get rid of the ordinary instruments, complicated and costly, often practically untrustworthy, to obtain more rapid execution with greater safety and certainty. In the first place De Rossi has adopted a small spoon, the concavity of which may be turned either to the right or the left, of an olivary form, with the edges somewhat sharp, attached to a curved stem with a metal handle. The mode of use is plain from its con-

struction. But the bulk of the tumour removed, there remains the base; or else one has to do with a small tumour projecting into another region, subglottic, where it is difficult to convey the ordinary instruments. For such papillomata De Rossi adopts his scarifier, a kind of forceps, with a flat extremity articulated between them, the upper surface of which is roughened. Introduced closed, they diverge and extract with rapidity. Finally, to prevent recurrence of the tumour, he recommends cauterization with a special instrument. His *porte-caustique* consists of a curved metallic rod, ending in an olivary body of platinum. On a depression in its surface, fused nitrate of silver is introduced in sufficient quantity. MASSEI.

**MASSEI, Prof. F.—A Case of Laryngeal Paralysis from Cortical Lesion.** (Clinical lecture reported by Signor N. Palazzolo.) *Archiv. Ital., Anno vii., fasc. 2.*

THE patient was an adult, who for five years suffered from right temporo-frontal headache, often combined with vertigo and slight dysphagia; and for the last year from dysphonia and attacks of dyspnœa. Examination of the nervous system disclosed a falling of the left cheek and a deviation of the tongue to the left. The ophthalmoscope revealed binocular choroiditis. The laryngoscope showed that the left vocal cord was almost immovable during inspiration, while during phonation it advanced to the middle line. The movements of the right cord were disorderly and sluggish.

In the first place the author spoke of laryngeal diseases related to defective abduction of the cord, then of the muscles involved, and ascribed the symptoms in the case to paralysis of the left abductor. Then he discussed the etiology, first of myogenic, then of neuropathic paralysis, and enumerated the causes which produce the one or the other. In regard to the present case, he confined himself to enunciating, as a general theory, that when there is unilateral paralysis affecting the crico-arytenoideus posticus, there are two possible contingencies, viz., pressure on the recurrent laryngeal, and, second, central lesion. He discussed the theories, referring to the various experiments and hypotheses of authors, and concluded as follows: It is possible with the laryngoscope to distinguish paralysis of the abductor from spasm of the adductor; it is always a question when the abductor becomes paralysed first; the phonatory position of the cord, whether one accepts the hypothesis of Semon or that of Krause, always indicates either a lesion of the recurrent or a central disturbance. He excluded, in the case, pressure on the recurrent; and seeing that the cerebral symptoms preceded the laryngeal, he concluded in favour of a central lesion. He believed lesions of the



nuclei on the floor of the fourth ventricle might be excluded, and so inferred a cortical change. He held that from experimental and clinical observations, there are two cortico-motor centres for the larynx.

MASSEI.

**GAREL** (Lyon).—**Some Remarks on a Case of Hæmorrhagic Laryngitis.** *Rev. Mens. de Laryngologie*, May, 1887.

By the term hæmorrhagic laryngitis is not meant the unimportant hæmorrhages, or simple filaments of blood which occur in some more or less acute forms of laryngitis. In these cases the symptoms are too slight to modify the clinical aspects of the condition. The term "hæmorrhagic laryngitis" should be limited to cases of laryngeal catarrh complicated with hæmorrhage, either superficial in position, or occurring in the deeper layers. The important sign is the occurrence of a hæmorrhage on the laryngeal mucosa, independently of any ulcerative lesion of the mucous membrane. The author quotes an observation of a patient with hæmophilia, whose general condition was bad. He had been troubled for many years with vocal affections, and for some months had rejected every morning blackish clots of blood. Laryngoscopically, there was observed on the free edges of the vocal cords, a sort of toothed border, formed of blackish blood-clots; clots were also observed on the arytenoids, and even upon the epiglottis. The mobility of the cords was intact, but the material obstacle formed by the clots hindered the free vibration of their edges, and affected the emission of sound. The voice, however, reappeared after the expulsion of the clots. The patient succumbed with albuminuria, œdema of the legs, and purpura with cardiac cachexia. Garel regards this observation as a true type of hæmorrhagic laryngitis, preceded by catarrhal laryngitis of simple rheumatic origin. Surgical intervention in such cases is likely to do more harm than good, and we must be contented with more or less astringent inhalations.

JOAL.

**SCHÄFFER AND NASSE** (Bremen).—**Tubercular Tumour of the Larynx.** *Deutsch. Med. Wochenschr.* No. 15, 1887.

SCHÄFFER extirpated with the cold wire a large tumour of the left ligament, which sprang from the arytenoid cartilage. At the time of the operation the patient was in the best possible health. Half a year later he died with phthisis.

Nasse made a microscopical examination of the tumour, and found it to possess a fibrous stroma, with a great number of small cells, along with giant cells. There were also very many tubercular bacilli.

MICHAEL.

**GOSSHOLF.**—Case of Ulcerating Broncho-tracheal Stenosis.

*Deutsch. Med. Wochenschr.*, No. 38, 1886.

A CASE of broncho-tracheal stenosis of probable syphilitic origin. A specific cure could not be obtained because the patient was already too much enfeebled. Tracheotomy was performed, application of König's canula made, but without relief. Post-mortem examination showed two ulcers in the under portion of the trachea. These ulcers communicated with an abscess which compressed the left bronchus.

MICHAEL.

**COMPAIRED Y CABODEVILLA** (Barcelona).—Importance of Etiology in the Treatment of Paralysis of the Vocal Cords. *Revista de Laringología, Otología, y Rinología*, Marzo, 1887.

THE author read an essay at the Spanish Laryngological Association, to show the value of etiological classification compared with a physiological or anatomical one.

RAMON DE LA SOTA.

**ROQUER CASADESUS** (Barcelona).—Multiple Papilloma. Very great Laryngeal Stenosis. *Revista de Laringología, Otología y Rinología*, Abril, 1887.

THE relation of a case which was remarkable for the great extent of the laryngeal surface occupied by the growth, and for the magnitude and multiplicity that it attained. After having extirpated the growth in three or four sittings, and having cauterized the origin of its growth, the patient breathed freely, and the voice reappeared, although not perfectly, still sufficiently to allow him to sustain a conversation. Microscopical examination showed the tumour to be a papilloma, without the presence of any bacilli.

RAMON DE LA SOTA.

**MASON, G. W.** (Bloomington, Ill.).—Intubation of the Larynx.

*Med. News*, March 26, 1887.

REPORT of three cases of diphtheria in which intubation was practised, in one of which the patient's life was saved by the operation, whilst in another death from laryngeal stenosis was prevented. From his previous unfavourable results with tracheotomy and that so far with intubation, the author presents the following points in favour of the latter operation:—(1) It involves no cutting and is bloodless; (2) hence patients readily consent to it when they would not to tracheotomy; (3) it gives a larger percentage of recoveries; (4) there is no risk of systemic infection because of an open wound; (5) there is no perceptible shock; (6) it does not expose the lungs to inflammation; (7) it does not preclude a subsequent tracheotomy.

J. N. MACKENZIE.

## NECK, &c.

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**SNELL, SIMEON.**—On some Clinical Features of Graves' Disease. *Lancet*, April 23, 1887.

THE author limits himself to the discussion of three eye-symptoms, viz., Stellway's symptom, or retraction of the eyelids, exophthalmos, and Graefe's sign, or loss of co-ordination between the upper eyelid and the eyeball. Of these he gives illustrative cases. He concludes by endorsing the central lesion theory of Sattler, who assumes a lesion of the vaso-motor centre which presides over the vaso-motor nerves of the thyroid gland and orbital tissues, it being inferred that these centres must lie close together. The cardiac symptoms he ascribes to lesion of the cardio-inhibitory centre of the vagus, and Graefe's symptom is explained on the assumption of a centre governing the associated downward movement of the eye and eyelids. The association of diabetes in some cases of Graves' disease the author considers noteworthy, seeing that the diabetic puncture is close to the vaso-motor area. The cases cited tend to support such a central theory.

GREVILLE MACDONALD.

**SHELLOWELL, OSCAR B.**—Cases of Hæmorrhagic Tendency in Myxœdema. *Lancet*, April 2, 1887.

THE author gives two cases in which severe hæmorrhage followed tooth extraction. He then gives quotations from various authors, from which he draws the conclusion that hæmorrhage in myxœdema assumes one of four forms, viz., menorrhagia, ecchymoses, bleeding from the gums, and purpuric patches on the skin. He then points out that certain pathological conditions in the disease may predispose to hæmorrhage, and quotes Dr. Bruce Low, who asserts that out of ninety cases of goitre who had borne children, thirty-one were habitual flooders.

GREVILLE MACDONALD.

**DRUMMOND, DAVID.**—On some of the Symptoms of Graves' Disease. *Brit. Med. Jour.*, May 14, 1887.

A CLINICAL lecture on three cases, with an admirable *résumé* of the leading symptoms and the various theories. The author draws special attention to pigmentation of the skin, which he describes somewhat minutely. With Wilks, Bristowe, Savage, &c., he has failed to detect any structural changes in the cervical ganglia. He leans to the view of a functional neurosis of the sympathetic, and

perhaps of the associated centres in the cord and medulla. He concludes with mentioning a case of Graves' disease in which the thyroid enlarged rapidly in one direction, during an attack of acute tonsillitis, while the eyes projected more than before. The thyroidal enlargement he believes to be simple hypertrophy.

GREVILLE MACDONALD.

**FÉRÉ.**—**Spasm of the Muscles innervated by the Hypoglossal.**  
*Soc. de Biologie, April 23, 1887.*

THESE spasms are usually limited to the tongue. Féré has just seen a patient in whom the spasms extended to the lingual and hyoid muscles. The patient was a woman of fifty, of neurotic constitution, and in whom, after extraction of a tooth, a pretty intense spasm occurred, consisting in sudden lowering of the jaw and protrusion of the tongue. A set of artificial teeth worn by the patient was at each spasm jerked out on to the ground.

JOAL.

**ANNANDALE, Prof. (Edinburgh).**—**Parotitis following Ovari-**  
**otomy.** *Edin. Med. Jour., March, 1887.*

IN a discussion which followed the reading of a paper of gynaecological interest, before the Medico-Chirurgical Society of Edinburgh, January 19, 1887, by Mr. Skene Keith, Mr. Annandale referred to this subject, and to an explanation of its occurrence which he had lately seen, to the effect that the removal of the ovary caused some interference with the salivary secretion, and the ducts in such a condition permitted the entrance of germs to the glands, and so caused the inflammation. He inquired of Mr. Keith if he had met with any case in which this might be a likely explanation of this condition. Mr. Keith had seen suppuration of the parotid after ovariectomy, but believed it was as common after other operations. (See "Case of Suppuration of the Parotid, following Ovariectomy," by Skene Keith, M.B., *Journal of Laryngology and Rhinology*, vol. i., p. 29.) (Mr. Annandale's question, which he pointed out had reference to inflammation, not suppuration, was not satisfactorily replied to.)

HUNTER MACKENZIE.

**SÖRENSEN (Copenhagen).**—**Report of the Copenhagen Hospital**  
**for Infectious Diseases (Meddelelser fra Blegdamshospitalet).**  
*Hospitalstidende, May 11, 1887.*

THE author, who is physician to the above-named hospital, has, during the year 1886, treated 496 cases of croup and diphtheria, which he considers identical diseases. (The post-mortem examination showed diphtheritic membranes of the fauces in 88 out of

101 cases of croup, and false membranes of the lower air-passages in 40 out of 55 cases of diphtheria without stenosis.) During life there were often no symptoms of any diphtheritic deposits in the air-passages in cases of usual diphtheria, whereas the post-mortem examination showed false membranes of these parts. He considers the danger of diphtheria to be in proportion to the extent of the diphtheritic process. The author draws attention to some symptoms of gastric disorders during diphtheria as being of very bad prognostic significance. These are first unconquerable dislike for food, and later, vomiting, which latter symptom often appears shortly before death, and he only saw one patient recover after having had these symptoms. He considers them due to pathological changes of the minute structures of the central nervous system. The post-mortem examination did not show any visible changes of the structure of the stomach, the brain, or the spinal cord. HOLGER MYGIND.

**THOMSON AND DEWAR** (Edinburgh).—**Clinical Report of the Cases in the Royal Hospital for Sick Children, from May to October, 1886.** *Edin. Med. Jour.*, May, 1887.

AMONGST the cases (353 in number) were the following :—

Diphtheritic croup, 5. In four of these, death occurred within a few hours of admission to the hospital.

Post-diphtheritic paralysis, 2. In one of these the soft palate, and in the other the vocal cords were affected.

The surgical cases (28 in number) embraced, amongst others, cases of ranula, wry neck, cellulitis of neck, and foreign body in the larynx. Death occurred in a case of cellulitis of the neck, following measles, in a child of one year.

The following are recorded amongst the specially noteworthy cases :—

*Mediastinal tumour* in a girl aged eight years. Precordial murmurs, tracheal stridor, attacks of dyspnoea, and cyanosis. Sudden death. Post mortem—large lympho-sarcoma, enveloping pericardium, and extending up the trachea as far as the cricoid cartilage.

*Pyæmia* in a boy of five, following acute necrosis of lower jaw. History of decayed teeth and recent gumboil.

*Bronchiectasis* in a boy of four, following pertussis.

In 25 cases of tuberculosis, no record is made of any laryngeal participation. HUNTER MACKENZIE.



## ASSOCIATION AND CONGRESS MEETINGS.

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### SIXTH CONGRESS FOR INTERNAL MEDICINE.

*Meeting, April 14th, 1887.*

*On the Physiological Value of Leucocytes of the Tonsils and Lingual Glands.*—ROSSBACH. From experiment the author has determined that the tonsillar secretion, as well as that from the glands of the tongue, possesses a saccharifying power. He further concludes that this power resides in the leucocytes, because the white corpuscles of blood and pus possess the same peculiarity.

*Meeting, April 15th, 1887.*

*The Pathology and Therapeutics of Whooping Cough.*—Professors VÖGEL (Munich) and HAGENBACH (Basle), who were selected to open the discussion, reviewed the different opinions now entertained as to the nature and treatment of this disease. All authors now concede it to be an infectious disease, but the microbe has not been isolated with certainty. It is not certain, further, how far it is a purely local or a general infection. Many authors believe that a neurosis is produced by the infection, and the place of the infection is generally believed to be in the upper respiratory passages, larynx, pharynx, or nose. As to laryngoscopic examination, while some authors note positive appearances, others have failed to find anything special. The principal methods of treatment in general use are, narcotics and antiseptics (belladonna, cannabis indica, opium, morphia, quinine, and chloral), or local treatment of the larynx, by inhalations and insufflations, and insufflations of benzoin and quinine into the nose. (Michael.)

MICHAEL (Hamburg) believed that the differences recorded in the laryngoscopic appearances are due to the fact of such examinations having been made at different stages of the complaint. If for some time there has been no attack the larynx appears to be normal, but immediately after an attack the mucous membrane is red, and especially in the posterior parts of the larynx. He commended his method of treatment by insufflations into the nose, and exhibited curves and tables of many cases in proof of the power of this treatment to arrest attacks and diminish mortality.

HEUBNER (Leipzig) had had very poor results from the use of many medicaments. Neither the length of time the disease lasts nor the nature of the attacks can afford proof of the value of any medicament, but only the variation in the number of the attacks.

UNGAR remarked that in some epidemics the characteristic whooping sound is absent, and this makes the diagnosis difficult.

SCHLIP (Baden Baden) recommended the pneumatic cabinet, turpentine, and sulphur.

COHN (Hanover) relied upon bromide of potash and musk.

### SIXTEENTH CONGRESS OF THE GERMAN SURGICAL SOCIETY.

*On Malformations of the Septum Narium.*—GEUZNER (Halle) differentiates two forms, viz., scoliosis of the septum and defect of the septum, of traumatic

origin. The author's operation for both kinds of malformation consists in cutting through and removal of the deviation with a bistoury.

VOLKMANN used to hold the opinion that deviations were always accompanied with fracture, but anatomists have convinced him that septal defects may often be congenital anomalies.

TRENDELENBURG had often observed that not only the septum, but also the upper jaw, is concerned in the deviation, and considers this a proof that the cause is not traumatic but congenital.

LANGE stated that he employed Jarvis's method of treatment for these conditions.

HEYMANN, in referring to a case of traumatic origin, stated that he always operated by cutting. MICHAEL.

## SOCIETIES.

### Midland Medical Society.

*Wednesday, March 30th, 1887.*

*Syphilitic Stenosis of Trachea.*—Dr. SUCKLING showed a woman, aged fifty, who had contracted syphilis twenty years previously; five years later the hard palate became perforated. For the last nine years she had suffered from difficulty in breathing, which was noisy and stridulous. On several occasions the dyspnoea had been extreme, and almost necessitated tracheotomy. There was no laryngeal stenosis or other disorder, the cords moving freely. On inspiration the glottis was rhomboidal in shape, being extremely dilated; nothing abnormal could be seen in the trachea. There were no signs of mediastinal tumour, no dysphagia, or other pressure symptoms.

### West London Medico-Chirurgical Society.

*Friday, April 1st, 1887.—Clinical Evening.*

*Malignant Polypus of the Nose.*—Dr. SCANES SPICER related the case of a woman under his care suffering from malignant polypus of the nose.

Mr. BRUCE CLARKE said that he had lately been watching a similar case to that described by Dr. Spicer. The polypus was removed with forceps; ultimately the patient died, and at the *post-mortem* examination an abscess at the base of the brain was found.

*Rhinolith.*—Mr. WEISS exhibited a rhinolith, which he had lately removed from a young girl.

Mr. BLAND SUTTON said such concretions usually formed around a foreign body.

### Epidemiological Society of London.

*Wednesday, April 13th, 1887.*

*Mould-Fungi as Causes of Diphtheria.*—Dr. MICHAEL W. TAYLOR read a paper embodying all the evidence which he had collected from many years' experience of outbreaks of diphtheria, in support of views which he had formerly expressed in the *British Medical Journal* of July, 1881. His view was that some common mould-fungi, growing under certain conditions, might originate or transmit diphtheria. The first set of cases comprised three children in one house, who took

diphtheria within a few days of each other ; they had not been exposed to infection, nor could the disease be traced to any external conditions, except the state of the bedroom they slept in. The walls, in consequence of leakage, had become sodden with wet on July 12 ; on July 22 a fungus appeared on the wet plaster ; on August 1 the first case of diphtheria appeared, rapidly followed by two others, in the children who occupied the room. At that time the surface of the wall was covered with aspergillus mould, besides which there was a surprising development of a pileate fungus growing on the wet plaster. In a second case, in which a child died in three days from diphtheria, there was a great development of penicillium moulds in the apartment. In another case, a young man had diphtheria severely, four days after having been engaged in cleaning out a loft in which a number of pigeons were kept, which was full of mould growing on the exuviae and *débris* and rotten woodwork. In a fourth case, four children in the same family were attacked, the only insanitary condition present having been a quantity of fleeces of sheep's-wool, which had been stored for two years within the house, in an adjoining room. Again, there had been three outbreaks of diphtheria in a farmhouse, one case in 1879, four cases in 1880, two cases in 1881. Here also wool had been stored within the house, and it was kept in a room which had been successively used by these children as a sleeping apartment. Dr. Taylor regarded the evidence as pointing strongly to the storage of wool, and to the mould spores and dust proceeding from it, as being the exciting causes of these successive outbreaks of diphtheria. He then discussed the probability of common moulds being connected in some way as agents in originating the diphtheritic growths. It was shown by the researches of Oertel, Nasiloff, Eberth, and others, that diphtheria was a true mycosis, and that we were warranted in believing that it depended on the implantation of fungoid material endued with virulent power. Evidence was sought from the analogy of other fungoid parasitic affections which infected man and animals ; it was shown that many of these fungal productions were but conversions of elementary states of penicillium and oidium. As maintained by Zopf, there might be a polymorphism amid pathogenic micro-organisms, and there might be stages of intermediate forms resulting from the nature of the nutrient media. Common moulds were capable of artificial growth in the bodies of animals ; the spores of aspergillus glaucus had been made to germinate in the eyes of rabbits, and there was a ready-made experiment in the madura foot-disease, which arose from inoculation with the spores of a mucor, growing in the hot season in India. The innocent bacteria and aspergillus might, by special cultivation, become pathogenic, according to Gräwitz and Fepinger. The experiments in this direction by Nägeli and Büchner were referred to, and also Lichteim's experimental inquiry on Pathogenous Mould-Fungi. Dr. Taylor regarded the primary elements of zymotic disease as dependent not on individual forms of germs, but as an affair of soil, and inferred that common moulds, both by spores and bysoid mycelium, might originate diphtheria by growing on noxious media.

### **Society of Medical Officers of Health.**

*Friday, April 15th, 1887.*

*Sore Throat from Coal-Gas.*—Dr. CORFIELD read a paper on "Outbreaks of Sore Throat, caused by Slight Escapes of Coal-Gas." He pointed out that attention had been almost entirely directed to cases of poisoning by asphyxia produced by escapes of coal-gas into dwelling rooms ; this had been shown to be due to the carbonic oxide contained in the coal-gas. He referred to the recent investigations of Professors W. T. Sedgwick and W. Ripley Nichols, of the Massa-

chusetts Institute of Technology, as to the relative poisonous effects of coal and water gas; these investigators concluded that carbonic oxide was probably the only component of illuminating gas the poisonous qualities of which were of practical importance to the public health. Michel Lévy, in his *Treatise of Hygiene*, suggested that some of the effects produced on persons working in atmospheres charged with the products of combustion of coal-gas might be due to unconsumed substances, such as bi-sulphide of carbon, but Dr. Corfield had been unable to find any account of definite illness produced by continuous slight escapes of coal-gas from defective burners or joints in pipes. During the past few years his attention had been gradually arrested by cases of illness, and more especially of relaxed and even ulcerated sore throats, occurring in persons sleeping in rooms in which there were defective gas burners or pipes, but living in houses as perfect as modern sanitary science could make them. The persons attacked became quite well on the defects in the gas burners or pipes being remedied, and no other cases occurred. Dr. Corfield himself had personally suffered from a slight escape of gas from a defective pipe in his own bedroom. He also pointed out that coal-gas might get into houses through the basement floor, and even up through the walls, especially behind panelling, from defective mains in the streets. He believed that the effective agents in producing the irritation in the throat were the bi-sulphide of carbon, and other sulphur compounds contained in the gas. To hospital throats and sewer-air throats must now be added coal-gas throats.

### Sheffield Medico-Chirurgical Society.

*Thursday, April 14th, 1887.*

*Malignant Tumour of Œsophagus.*—DR. J. D. WYNNE showed an œsophagus which was involved in a scirrhus mass for about six inches downwards from just above the root of the lung. The patient, aged seventy-nine, had suffered for about a year from occasional dysphagia, which became worse during the last three weeks of life, so that eventually all food was rejected.

### South Wales and Monmouthshire Branch British Medical Association.

*Thursday, April 28th, 1887.*

*Sub-glottic Abscess.*—W. T. F. DAVIES showed the larynx of a woman, aged sixty-three, who had died suddenly after an attack of dyspnoea lasting twenty minutes. A small laryngeal abscess below the vocal cord, and running all round the larynx, with consequent œdema, was found. The aortic valves were calcified, and in the interventricular septum was found a small aneurysm.

### Hamburg Society of Physicians.

*Meeting, April 5th, 1887.*

A CASE of congenital absence of the thyroid gland was shown by E. FRAENKEL.  
MICHAEL.

### Wiener Doctorencollegium.

*Meeting, April 18th, 1887.*

*On Asthma.*—SCHNITZLER gave a review of the present state of this question. Four years ago the nose was too little considered in relation to asthma. Now, on the contrary, all cases are looked upon as produced by affections of the nose. During the attack, narcotics give the best results.

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PUIS recommends tinct. strophanti, which he had also administered, with good results, in cases of cardiac asthma.

MICHAEL,

### **Surgical Society.**

*Paris, April 20th, 1887.*

*Tracheotomy and Chloroform.*—M. LE DENTU returns to this question (see last number of this Journal, p. 192), and insists on the fact that he has never maintained that chloroformisation in tracheotomy was anything new. It is, however, rare in France. Notwithstanding the widely-expressed dislike of the method, it is necessary to impress the medical fraternity of France that in certain conditions chloroform narcosis is rational in tracheotomy.

PEYROT thought that there was another condition in which it might be of great service, especially in children, *i.e.* in tonsillotomy. The inconveniences of the method are minimal, so long as anæsthetism is not pushed too far, deglutition being maintained, blood would flow into the stomach, and not into the respiratory passages. It can also be used for removal of adenoid vegetations, and permits as much to be done in one sitting as at seven or eight sittings without chloroform.

RECLUS had experience of one case of tonsillotomy under chloroform, in which the blood entered the respiratory tract and caused death. This fact was not published, but shows nevertheless that extreme care is necessary in such conditions.

JOAL.

### **Medical Society of the Hospitals.**

*Paris April 22nd, 1887.*

*Treatment of Tubercular Laryngitis.*—GOUGENHEIM communicated the results obtained by the surgical treatment of tubercular laryngitis introduced by Hering, of Warsaw, *i.e.*, the employment of scraping the ulcerations; or when practicable, the injection of lactic acid or iodoform into the submucous tissue of the larynx after cocaine anæsthesia. Out of 200 patients so treated during the last year, Hering reported 28 cures. Gougenheim showed sections of the larynx demonstrating the cure of tubercular ulcers; the products of scraping infiltrations of the same nature, and chromo-lithographic drawings of ulcerations cured with cicatrization. In these cases the characteristic bacillus had been detected, and the truly tuberculous nature of the lesions had been affirmed by Virchow. At the present time some of the 28 reported cured have died from other causes.

LABBÉ considered that such observations as the preceding should not be permitted to pass without great reserve. He did not for a moment doubt the good faith of the operator, or of the speaker, but it was possible for them to be deceived, and there would be some danger in publishing without commentary or thorough examination facts so extraordinary as those just related, and thus inspiring practitioners with unjustifiable confidence.

GOUGENHEIM answered that the sections had been shown to Virchow, at Berlin, and Hering was a serious physician.

JOAL.

### **Academy of Medicine.**

*Paris, April 26, 1887.*

*Treatment of Certain Rebellious Epistaxes.*—Before entering into the question, VERNEUIL recalls the probability that when an epistaxis is not caused by a neoplasm of the nasal fossa or pharynx it should be considered to be a symptom of toxæmia,



or at least of a dyscrasia. Hence the necessity of giving the foremost place in treatment to anti-hæmorrhagic medicaments taken internally, and only a secondary rôle to physical, chemical, and mechanical methods of treatment, designed to meet the symptom but not the cause. If he were to recapitulate all his treatment of epistaxes occurring in cardiac, renal, or hepatic disorders during fevers, or from malaria, he would relate many more successes obtained from digitalis, ergot, and sulphate of quinine than from direct cauterization or tamponning. VERNEUIL relates three cases of rebellious epistaxis in which medication was powerless, and tamponning was equally unsuccessful. Seeking the origin of the condition, he found it in one of the great viscera of the economy, namely, the liver, and applying a large blister to the hypochondrium, obtained an immediate cure. In these cases ergotine, perchloride of iron, digitaline, and quinine had all been tried without effect. VERNEUIL, in closing his remarks, concluded that :—1. Latent affections of the liver can provoke or keep up obstinate epistaxis. 2. The revulsion obtained from placing a large blister on the right hypochondrium is the best means of curing hæmorrhages of this kind.

COLIN asked VERNEUIL what physiological relation he saw between æpistaxis and an affection of the liver, and how he could explain the action of a revulsive applied to the hypochondrium? VERNEUIL was unable to trace the connection; but inasmuch as all cases showed the same chain of events, it was more than mere coincidence. COLIN thought that it was possible to obtain a physiological explanation. Physiologists knew that in cardiac affections, in which there are circulatory disorders, there are venous pulsations in the jugulars and the cerebral veins. It is the same in certain affections of the lungs with embarrassment of respiration, in hypertrophy of the liver and spleen. In all these cases there is an increase of vascular tension, which with ease will produce epistaxis. As to revulsion, COLIN believed it to be an error to apply it near to the seat of disorder; it would often augment the fluxionary state which it is desired to overcome, and revulsions should be applied to a spot as far away as possible from the congested region. DUJARDIN-BEAUMETZ believed it possible to give a scientific explanation of Verneuil's facts. Hæmorrhages consecutive to hepatic diseases arise: (1) from alterations of the blood, a powerful factor predisposing to hæmorrhage; (2) from the manner in which liver diseases react upon the heart; (3) that they lead to alterations in the capillary blood-vessels, and these being in the pituitary membrane, the most delicate in the body, there is nothing surprising in the fact that they should oftenest yield.

JOAL.

### Section of Laryngology.

*Ninth International Medical Congress, to meet in Washington, D.C., U.S.A., September, 1887.*

The following gentlemen have signified their intention of presenting papers:—Dr. B. Baginsky, Berlin, Germany; Dr. S. N. Benham, Pittsburgh, U.S.A.; Dr. A. Cartaz, Paris, France; Dr. W. E. Casselberry, Chicago, Ill., U.S.A.; Dr. W. Cheatham, Philadelphia, U.S.A.; Dr. A. J. Coey, Chicago, U.S.A.; Dr. W. W. Cole, Allegheny, U.S.A.; Dr. W. F. Coomes, Louisville, U.S.A.; Dr. Ephraim Cutter, N.Y., U.S.A.; Dr. H. H. Curtis, New York, U.S.A.; Dr. W. H. Daly, Pittsburgh, U.S.A.; Dr. T. D. Davis, Pittsburgh, U.S.A.; Dr. C. M. Desvernine, Havana, Cuba; Dr. Richard Ellis, Newcastle-on-Tyne, England; Dr. Richardson Gray, Orange, N.J., U.S.A.; Prof. Jos. Gruber, Vienna, Austria; Prof. Hack, Freiberg in Baden, Germany; Dr. J. H. Hartman,

Baltimore, U.S.A. ; Dr. Herman E. Hayd, Buffalo, U.S.A. ; Dr. D. A. Hengst, Pittsburgh, U.S.A. ; Dr. Theodore Hering, Warsaw, Poland ; Dr. Camalt Jones, London, England ; Dr. H. Jones, London, England ; J. P. Klingensmith, Blairsville, U.S.A. ; Dr. Paul Koch, Luxembourg, France ; Dr. H. Krause, Berlin, Germany ; Dr. Geo. Mackern, Buenos Ayres, Argentine Republic ; Dr. Geo. W. Major, Montreal, Canada ; Dr. F. A. Mandeville, Rochester, U.S.A. ; Dr. F. Moura, Paris, France ; Dr. D. F. Massei, Naples, Italy ; Dr. A. W. Orwin, London, England ; Dr. M. C. O'Toole, San Francisco, U.S.A. ; Dr. Wm. Porter, St. Louis, U.S.A. ; Dr. D. N. Rankin, Allegheny, U.S.A. ; Dr. J. M. Ridge, Camden, N.J., U.S.A. ; Dr. J. O. Roe, Rochester, U.S.A. ; Dr. John A. Robinson, Chicago, U.S.A. ; Dr. O. Rosenbach, Breslau, Germany ; Dr. A. Schnee, Nice, France ; Prof. John Schnitzler, Vienna, Austria ; Dr. Schaumacher, Achen, Germany ; Dr. Carl Seiler, Philadelphia, U.S.A. ; Dr. J. G. Sinclair, Nashville, U.S.A. ; Dr. F. Semeleder, City of Mexico ; Dr. Max Stern, Philadelphia, U.S.A. ; Dr. J. A. Stucky, Lexington, U.S.A. ; Dr. Richard Thomas, Baltimore, U.S.A. ; Dr. W. McNeil Whistler, London, England ; Dr. Edward Woakes, London, England ; Dr. Zeim, Danzig, Germany.

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## REVIEW.

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### **Stemmens Pleje og Uddannelse Paa Dansk ved Dr. Med. Holger Mygind, Copenhagen.<sup>1</sup>**

DR. MORELL MACKENZIE's interesting and well-known work, "Hygiene of the Vocal Organs," has been translated into Danish by Dr. Holger Mygind, of Copenhagen, where it has been well received both by the medical profession and the general public. While compelled by the exigencies of the language to eliminate some of the absolutely untranslatable idioms, as well as various allusions and remarks which, being only of interest to an English public, nevertheless contribute to render the original so eminently readable, and make an otherwise "dry" subject interesting, the translator has very carefully and accurately reproduced the author's ideas, and in all important points and details given a verbatim translation. We think that Dr. Morell Mackenzie has every reason to be satisfied with the result of Dr. Mygind's endeavours to make the work as deservedly popular in Denmark and Norway as it is in this country.

C. B.

<sup>1</sup> "The Hygiene of the Vocal Organs," by Morell Mackenzie, M.D., translated into Danish by Dr. Med. Holger Mygind, Copenhagen. Macmillan & Co., London.

## OBITUARY.

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### WILHELM HACK.

ON April 23, Professor Hack died with great suddenness from apoplexy during a tricycle excursion. This lamented laryngologist was only thirty-eight years of age at his decease, but his name had been widely known for some years in association with his theories of the nasal origin of reflex neuroses. Though we cannot agree with the somewhat extravagant developments of these theories, we must admit that Hack was the first to bring the subject into prominence. The most important of the many papers published by him dealing with laryngological and rhinological subjects was undoubtedly his essay, entitled "Ueber eine operative Radicalbehandlung bestimmter Formen von Migräne, Asthma, Heufieber, sowie zahlreicher verwandter Erscheinungen," which appeared in 1884. It is true that he found it necessary later to modify his too enthusiastic conclusions, and it is possible that had he lived he would have seen reason to disclaim much that is extravagant and erroneous, and which has been advanced by aid of inaccurate observation and imperfect theory by his too enthusiastic followers. Nevertheless, there is a basis of scientific value in the theory of nasal neuroses, and to Hack undoubtedly belongs the great credit of first drawing attention to the subject. For this, he deserves a place in the history of rhinology to be written in the future. Professor Hack was distinguished by great personal amiability, and all who knew him in his social relations must feel that they have lost an excellent friend. Laryngological science has lost in him an ardent and able exponent.

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## NEW INVENTIONS.

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### CHLORIDE OF AMMONIUM INHALERS.

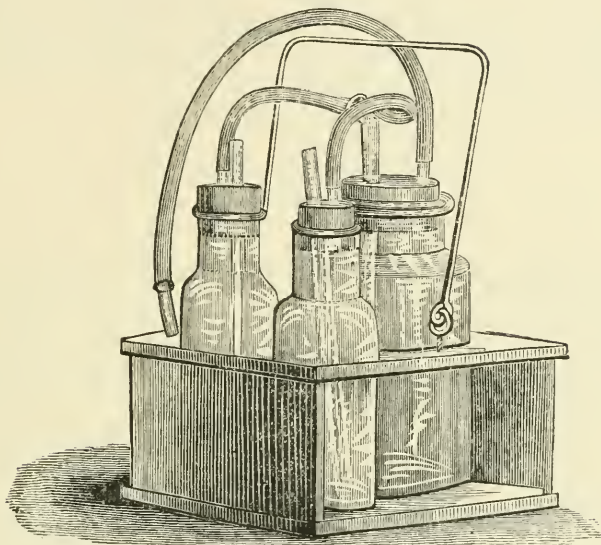
#### 1. The Burroughs Chloride of Ammonium Inhaler (Vereker's Patent).

The Burroughs inhaler is constructed after the following plan:—

There is a large bottle for water, a small one for acid, and another for ammonia solution.

The water bottle has two tubes; one does not touch the water, and is the draw tube for applying suction; the other tube dips under the water, and divides externally into two branches, one of which goes to the bottle of acid, and the

other to the bottle of ammonia. Two straight tubes pass through the corks into the acid and the ammonia solution.



When suction is made on the *mouth-piece*, air rushes into the small bottles, becomes saturated, and forms a vapour of chloride of ammonium on meeting in the branched tube passing into the *water* bottle. The medicated air is thus washed before passing into the mouth-piece, and is pure, white, and nearly tasteless.

## 2. Basdon Smith's Inhaler.

The bottle being half-filled with water, and the india-rubber stopper firmly inserted, the apparatus is charged by lifting out the piece of pumice-stone by means of the platinum wire, and dipping it into hydrochloric acid. The solution of ammonia is dropped on to the sponge. Suction made on the mouth-piece draws the fumes of chloride of ammonium through the apparatus, and in passing through the water, they are well washed.



Both apparatus are well suited for the purpose for which they are intended. The Burroughs inhaler is a very perfect apparatus, and is highly to be recom-

mended. The inhaler invented by Basdon Smith is in every respect good, and it has the advantage of being cheap in cost. Its price of 5s. 6d. is less than half that of the Burroughs inhaler. It is a compact and serviceable apparatus, and having used it for some time we can confidently recommend it. Burroughs' inhaler possesses the advantage over all others that it need not be recharged every time before using.

These two inhalers are decidedly the best in the market.

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## NOTES.

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**The Treatment of Pulmonary Phthisis by Gaseous Enemata.**—We have received the following communication from the editor of *The Polyclinic*, and willingly insert it as requested:—"Dr. HENRY LEFFMANN, editor of *The Polyclinic* (P. O. Box 791, Philadelphia), desires to obtain results of the new treatment of Pulmonary Consumption and Phthisis by Gaseous Enemata, for publication in *The Polyclinic*. The correct therapeutic value of this method can only be arrived at by the collection of statistics, and he therefore requests any one who has administered the gas to communicate the result to him, the formula used, and any special information that may be useful."

**The American Laryngological Association.**—At the meetings of this Association just held at the hall of the New York Academy of Medicine, 26th, 27th, and 28th May, a large number of papers were presented. Some of these were of great interest, and will be referred to later on in this Journal. The members of the Association were entertained at supper by Dr. George M. Lefferts, and the annual dinner was held at Delmonico's on the 27th May.

**German Society of Physicians and Naturalists.**—The sixtieth meeting of this Society will be held at Wiesbaden, from September 18th to 24th, under the presidency of Drs. Fresenius and Pagenstecker. An exhibition of apparatus, instruments, and anatomical preparations relating to the various sections will be opened at the same time. The eleventh section of the meeting is that of Laryngology.

**Acuteness of the Sense of Smell.**—Messrs. Nicholls and Bailey recently contributed to *Nature* the results of a series of experiments to test the acuteness of smell in the sexes and different individuals. The sense in the male was found to be more acute, on the average, than in the female. In some individuals it was so keen as to detect one part prussic acid in two million parts water. Several substances were experimented with, such as cloves, nitrate of amyl, extract of garlic, &c.—*Med. News*, April 23, 1887. (From *Science*, March 25, 1887. Philadelphia.)

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*Letters relating to the Editorial business of the Journal are to be addressed "To the Editors."*

*Business communications to be sent to the Publishers, Messrs. J. & A. Churchill, 11, New Burlington Street, London, W.*



THE  
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THE TREATMENT OF PHTHISIS.

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IN the light of modern pathology, we must regard phthisis as a bacillary disease, and the serious constitutional symptoms as primarily induced by the growth and development of this bacillus. When we come to interrogate the mode of action of the bacillus we are, however, met with difficulties. We have, indeed, two great factors—viz., a local lesion, consisting of tissue change, ending in two ways, according as the process is rapid or slow, the ultimate result being in the one case, ulceration and destruction, and, in the other, organization and fibroid change; and besides the local lesion, we have a chemical process, which involves the poisoning of the whole organism. Many pathologists, indeed, now regard the phthisical process as one in which there is a local lesion, with the production of a general state of septicæmia. Whether bacillary poisoning is produced through the manufacture of ptomaines, or the “ferment intoxication” or other chemical processes, is one of the most vitally interesting, if also one of the most obscure points, in chemical pathology. The general condition is, however, one of septicæmia.

The indications in the treatment of pulmonary phthisis would therefore appear to be—1st, to arrest local action; and 2nd, to alleviate the general condition consequent upon the local lesion. The first indication may be met by destroying the bacillus, which is the *fons et origo mali*, or by putting the tissues into such a resistant condition that they are enabled to withstand the ravages of the parasite by rendering its surroundings unsuitable. The means taken to produce the one effect cannot fail to accomplish the other. To this end prophylactic measures become of prime importance, and the earlier they are adopted to combat the “phthisical tendency,” the greater is the hope of success. To such means must we look as will aid pulmonary expansion, such as the pneumatic apparatus and inspirations of compressed air, for the purpose of accomplishing increase in the intra-pulmonary pressure, with consequent expansion

of the chest, and gain in the functional activity of the lungs. The same effect is obtained by causing the patient to expire into rarefied air, and for this purpose physicians have lately looked to residence in high altitudes as an effective prophylactic measure. For the same purposes "respiratory gymnastics" and the "pneumatic cabinet" are employed. But, supposing the tissues to be already invaded, the bacillus firmly seated, and its ravages already past simple prophylactic measures, what is to be done? We naturally turn to anti-bacillary methods and antiseptic medication, and it has been sought to accomplish this end by—1, pulmonary inhalation; 2, internal medication through the stomach; 3, direct injections into the pulmonary tissues; and lastly, 4, by rectal injections.

In pulmonary inhalations it is not unlikely, as pointed out by Hassall, that a large part of what is introduced through the mouth does not reach the lungs at all, but no one can deny that benefit is derived from the use of antiseptic inhalations such as carbolic acid, creosote, iodine, eucalyptol, iodoform, the essential oils, such as pine, &c. Continuous inhalation may be obtained by the employment of medicated respirators. With regard to the inhalation of gases, such as sulphuretted hydrogen (obtained at such spas as Aix-la-Chapelle, Eaux Bonnes, Cauteret, Luchon, Harrogate, &c.), carbonic acid (as obtained at Ems, Franzenbad, Kronthal, &c.), certain beneficial effects are recorded by balneo-therapists, and  $H^2S$  is particularly said to diminish the frequency of the pulse, calm the dry irritative cough, aid expectoration, and promote a feeling of exhilaration; while  $CO^2$  is said to be invigorating and stimulating. While great effects have been claimed from the inhalation of oxygen and nitrogen, it is really doubtful how far these reputed results are reliable. Pulmonary inhalations of gases or medicated vapours, while undoubtedly very serviceable, have not accomplished the success that might have been expected from them in the treatment of phthisis. We have lately heard propounded a mode of treatment of pulmonary disorders, and especially phthisis, which, while certainly raising our scepticism, cannot, in the light of very recent experience, be so readily dismissed. In 1886, Bergeon,<sup>1</sup> of Lyons, published a plan of treating pulmonary phthisis by the rectal injections of gases. The method has been adopted extensively in France and America, and one is bound to accept the gratifying reports of the many well-known physicians,<sup>2</sup>

<sup>1</sup> In a paper presented to the French Academy of Sciences, July 12, 1886, and Congress for the Advancement of Science, August 12, 1886.

<sup>2</sup> Osler, Solis Cohen, and others in America; Chantemesse, Vuillet, Garcl, Queyrel, Renault, Cornil, and others in France; Burney Yeo, Bennett, Coghill, &c., in England, and many others.

whose preconceived and natural dislike and scepticism has yielded to very favourable considerations of Bergeon's method. The method, which consists of injections per rectum of sulphuretted hydrogen gas combined with carbonic acid gas, or of the latter gas alone, is founded on the assumption that it would poison the individual to administer a dose of any antiseptic inhalation by the lungs directly, sufficiently large to kill the bacilli, since such medicaments directly enter the pulmonary arterial system, and toxic substances introduced in this manner act very rapidly and fatally. Cl. Bernard long ago showed, however, that large quantities of sulphuretted hydrogen could be introduced through the digestive tract, or into the venous system, with impunity, provided the injections were not made in too great quantity at a time. The good effects of carbonic acid gas in phthisis and asthma had already been noted long ago, by Demarquay and others, and seltzer water had been injected into the intestine in quarts, and even bicarbonate of soda along with tartaric acid, in order to obtain production of  $\text{CO}^2$  *in situ*, and distension of the intestine by the gas in cases of intestinal obstruction. Large quantities of sulphuretted hydrogen might be administered by the stomach, but such medication, of necessity, disorders the digestive organs, and prevents proper assimilation of food. Consequently the method is inapplicable, but there is no doubt that large quantities of these gases can be introduced into the lower alimentary tract with perfect safety, and being received directly into the venous circulation, are carried through the portal system, hepatic veins, and right heart directly to the lungs, where they are brought into contact with the diseased pulmonary tissue, and exhaled through this channel without producing any untoward effect. This plan is therefore the most likely to succeed in producing direct medication of the lung tissue. When we look for clinical evidence of the beneficial effects of this method, we find a mass of recently accumulated literature, and making due allowance for the exaggeration which accompanies enthusiasm in therapeutics, and for the fact that temporary good results habitually follow new methods of treatment, we are bound to confess that the method is rational, and that reports from various quarters where it has been adopted lead to the inevitable conclusion that Bergeon's method is a distinct advance in the science of respiratory therapeutics.

Bergeon employed chlorine, turpentine, ether, ammonia, bromine, iodoform, and eucalyptol for rectal injection, but finding that inflammation, and even sphacelus, of the intestine resulted from their irritant action, abandoned all these for the mixture of sulphuretted

hydrogen and carbon dioxide. He concluded that the latter gas lessened the irritant action of the sulphur, which in turn is a micro-bicide. This, however, at least seems to be certain, that the sulphuretted hydrogen does not kill the tubercle bacilli, for, according to clinical evidence, they are as numerous in the sputum of phthisical patients under treatment as before the injections were begun. While some<sup>1</sup> are inclined to attribute the good effects to the action of the sulphur upon the inflamed lung tissue, denying its parasiticide action, others, and from our short experience of the method we are inclined to agree with them, consider the carbon dioxide to be quite as effective alone as the admixture of the gases. Chantemesse and Ballet<sup>2</sup> have, indeed, employed carbon bisulphide with excellent results.

The cases in which these rectal injections may be employed with every hope of success, and this appears to have been sometimes striking (H. C. Wood, Solis-Cohen, and others), are not only phthisical, but asthma, with chronic catarrh and emphysema, and even catarrhal pneumonia, bronchitis, whooping cough, and pulmonary catarrh. Dr. Wood states that he saw one case of catarrhal pneumonia with an enormous amount of purulent expectoration, and general symptoms so bad that a fatal prognosis had been given, in which the administration of the remedy was at once followed by rapid lessening, and even cessation of the purulent secretion, and in a short time by convalescence. He cites another case of pleurisy and broncho-pneumonia in which a fatal prognosis had been given, and in which the expectoration, previously amounting at times to a pint in twenty-four hours, was notably decreased by gaseous injections within forty-eight hours, and convalescence followed.

Ramon de Fougerey<sup>3</sup> maintains that rectal injections are the best of all treatment for hæmoptysis, attributing the good effects, however, to the carbonic acid. Thiery and Renault<sup>4</sup> have employed the mixture of  $\text{CO}_2 + \text{H}_2\text{S}$  in phthisis, and the  $\text{CO}_2$  alone in emphysema complicated with bronchial catarrh. There is physiological evidence that  $\text{CO}_2$ , in small quantities, stimulates the respiration and the pulmonary circulation, either by direct stimulation of the medulla (Germain-Sée) or by increasing the contractility of smooth muscle (Brown-Séquard). In so doing, the plethora of the bronchial circulation, and the bronchial catarrh consequent on such a condition

<sup>1</sup> Dr. H. C. Wood, *Therapeutic Gazette*, April, 1887.

<sup>2</sup> *Gaz. des Hop.*, Feb. 3, 1887, p. 117.

<sup>3</sup> *Gaz. des Hop.*, Feb. 12, 1887.

<sup>4</sup> *Gaz. des Hop.*, 1887, p. 112.

is relieved by the emptying of over-distended pulmonary alveoli, and reopening of pulmonary capillaries closed through such distension. In conditions such as phthisis, where there is a large surface of inflamed lung tissue, it is possible that the direct application of sulphur to the tissues is followed, as is pointed out by Dr. H. C. Wood,<sup>1</sup> by the rapidly beneficial effects noticed from the application of sulphur to mucous membranes generally, and it is to this agent, and not to the carbon dioxide, that the beneficial effects must probably be attributed. S. Solis-Cohen<sup>2</sup> related a case of asthma in which striking relief followed the gaseous injections, confirmatory of the similar observations contained in Morel's<sup>3</sup> brochure.

The good results claimed for the treatment are : diminution of temperature and of night sweats, of cough and expectoration, arrest of hæmoptysis, promotion of appetite, strength, and a general feeling of well-being, with arrest of inflammatory and suppurative processes in the lungs, and control of the septicæmic process. Bergeon claims to have observed cicatrization of cavities and cure of ulcerations in patients under this treatment.

The method of administering the gas is of importance. The invention of the original apparatus has been followed by the introduction of others. We have now the apparatus of Morel, Sehet (in which regulation of the quantity of gas injected is permissible), Gallante, Kyner (made for Dr. Solis-Cohen), and lastly, of Faucher. The last is quite new, and appears to possess considerable advantages over the others. Its action is automatic, the liberation of gas is slow, so as not to give rise to distension, the quantities of gas employed are regulated by the dose of the salts used, and, most particularly, the patient can readily use the apparatus himself. Lecorché and Cornil speak highly of the apparatus. A simple appliance has been suggested and used by Dr. Bracken : <sup>4</sup> "An ordinary siphon bottle of carbonic acid gas and water, a pound bottle containing the sulphide in solution, closely corked, and containing a long inlet and short outlet tube, both of glass ; a rubber tube attached to the siphon connecting it with the bottle containing the sulphide solution, and the tubing with the metal tip of an ordinary fountain syringe conveying the sulphuretted hydrogen from this bottle, where it is generated, to the rectum. The siphon being inverted and the cock opened the carbonic acid gas escapes, and the supply can be regulated

<sup>1</sup> *Ther. Gazette*, April, 1887.

<sup>2</sup> *N. Y. Med. Journal*, May 28, 1887.

<sup>3</sup> *Nouveau Traitement*, &c. Masson, 1886.

<sup>4</sup> *Med. News*, May 7, 1887.



easily. The ordinary siphons obtained at a chemist's will serve for two or more enemata, and one attendant can readily invert the siphon and watch the effect on the patient, while the latter controls the rectal tube." It is said that the natural mineral waters are better than the artificially prepared gaseous solutions, being more effective, and causing less pain; such as red sulphur springs, Mount Clemmens, Sharon Springs, Belcher water, or Eaux Bonnes, Cauterets, and Challes water, which are preferred in France. The artificially prepared gas may be obtained from the following formula, which has been extensively employed in the Philadelphia hospital:—

R	Sodium sulphide (pure),		
	Sodium chloride (pure)	... āā gr. v.	
	Water	... ..	ḡxxii. ℥.

(About ten grains of each are put into the Woulffe's bottle, through which the  $\text{CO}^2$  passes. Each patient receives at each treatment from three to five pints of  $\text{CO}^2$ , the quantity of  $\text{H}^2\text{S}$  being unknown, variable, and small.<sup>1</sup>)

Or, if a stronger solution is required:—

R	Sodium sulphide (pure)	... gr. x.
	Dilute hydrochloric acid, U.S.P.	℥xxx.
	Water	... .. ḡxxii.

Keep on hand for use, and freshen up with both from time to time.

The probable reaction is  $\text{Na}^2\text{S} + \text{H}^2\text{CO}^3 = \text{Na}^2\text{CO}^3 + \text{H}^2\text{S}$ .

The solutions employed in the Hôpital Cochin are:—

1. Pure sulphide of sodium, 10 grammes (or 10 parts by weight)  
Distilled water enough to make 100 c.c. (or 100 parts by weight).

One c.c. disengages exactly 10 c.c. of  $\text{H}^2\text{S}$ , when the following solution is added:—

2. Tartaric acid, 25 grammes (25 parts by weight).  
Salicylic acid, 1 gramme (1 part by weight).  
Distilled water to 100 c.c. (100 parts by weight).

Fifteen c.c. of the two solutions, mixed with 250 grammes of water, yield 150 cubic centimetres of  $\text{H}^2\text{S}$ , and is similar to a litre of Challes water.<sup>2</sup> Four to five litres of carbonic acid gas are also employed. Bergeon<sup>3</sup> himself preferred the Eaux Bonnes or Challes water.

<sup>1</sup> Wood: *Therap. Gaz.*, April, 1887.

<sup>2</sup> Dujardin-Beaumeiz: *Société de Thérapeutique*, December 22, 1886, and *Progrès Médical*, Jan. 8, 1887.

<sup>3</sup> *Prog. Méd.*, Jan. 29, 1887, p. 97.

If instead of sulphuretted hydrogen, medicaments, such as iodoform carbon disulphide, eucalyptol, &c., are used, the wash-bottle is replaced by a glass tube, and the medicament is placed between two tampons of cotton wool, the ends of the tube being closed with rubber stoppers ; the  $\text{CO}^2$  is made to pass through one end, and is thus charged with the medicament ; the other end is connected with the rectal nozzle.

With the apparatus sold by Gallante, cartouches of tartaric acid and bicarbonate of soda are supplied, each of which will fill the gas holder to the extent of 5 litres of  $\text{CO}^2$  ; this gas is passed through a bottle containing the sulphuretted hydrogen (in the form of Eaux Bonnes sulphuretted mineral water). These different apparatus are best understood by reference to the original brochures, where illustrations and descriptions are to be found.

The amount of sulphuretted hydrogen that will poison a dog at once, appears from Peyron's experiments to be 150 c.c. Morel says that the dose for a man should be 25 c.c. Caution must be used in the employment of the gas. Dr. Wood states that in the University Hospital in Philadelphia, about a quart of a mixture containing equal parts of  $\text{CO}^2$  and  $\text{H}^2\text{S}$  injected into the rectum of a patient produced unconsciousness, and almost fatal symptoms within three minutes. A fatal result has already been recorded. Until it is seen that the patient can stand the injections, and until the dose has been regulated, it would appear wisdom not to entrust the treatment to any but those who are scientifically acquainted with its rationale and possible consequences. The rules laid down by Morel<sup>1</sup> were : 1. The breathing must be watched during the whole time of the injection ; any deficiency of respiratory power indicates diminished power to exhale the gas, and the injections should be regulated accordingly. 2. The quantity of  $\text{H}^2\text{S}$  injected should be small, and not more than 25 c.c. at a time. 3. The resistance to the entry of the gas into the rectum should be noted, and no undue pressure made upon the injecting bulb. 4. The injection should be made slowly, and with pauses between each closure of the bulb, so as to ensure complete absorption and exhalation, and avoid accumulation of the gas in the intestine. 5. About twenty to thirty minutes should be employed over each injection. 6. The rectal injections should be made three or four hours after meals, or a little before them. 7. At first only 3 litres of  $\text{CO}^2$  should be employed, afterwards 6 litres may be employed—morning and evening.

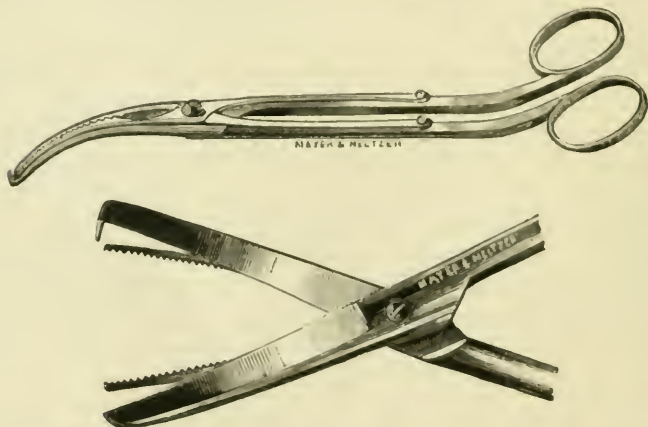
<sup>1</sup> Morel : *Nouveau traitement des affections des voies respiratoires*, &c. Masson, 1886.

Many observations are at hand to show the advantages of the method in pulmonary complaints. We want well-recorded results of the plan employed for the most distressing form of phthisis, viz., laryngeal phthisis. It is doubtful whether the rectal injections are really any more efficacious than the administration of sulphuretted hydrogen by other less objectionable methods. Very excellent results have been claimed for the administration of  $H^2S$  by means of the stomach, and Dr. Wood recently recorded his opinion that the administration of half an ounce to one ounce of saturated  $H^2S$  solution in a tumbler with two or three ounces of  $CO^2$  water run into it from a highly charged siphon, and given three to five times a day, is quite as effective as the rectal injection. We have ourselves recently obtained most beneficial results from the administration of Eaux Bonnes and  $CO^2$  water, in a case of asthma with pulmonary catarrh and emphysema, in which ordinary remedies failed. The methods may sometimes be combined with advantage. Our own experience, derived from experiments in progress at the Throat Hospital in London, has led us to think well of the new treatment, and to endorse the opinion expressed by Cohen before the Philadelphia County Medical Society, "That sufficient evidence exists to demonstrate its value as a legitimate therapeutic measure." R. N. W.

## INSTRUMENTS AND THERAPEUTICS.

**MACDONALD, GREVILLE.**—A New Uvulatore. *Lancet*, May 7, 1887.

THE object of the instrument is to leave the cut surface on the



posterior aspect of the uvula, without drawing the latter forwards

with forceps; which process, according to the inventor, tends to denude the muscular substance of mucous membrane. The only objection to the instrument is that the operator is dependent upon the velum being kept at rest in the lax condition. But in this there is seldom any difficulty, since the elongated uvula is generally accompanied by a semi-paretic condition of the palate, both conditions being probably dependent upon congestion, the latter affecting the muscular structures as well as the mucous membrane.

**SCHUTZ** (Mannheim). — **Forceps for the Removal of Adenoid Vegetations of the Naso-pharynx.** *Centralblatt für Chirurg. u. Orthopæd. Mechanik.* 1886.

THIS instrument differs from all other cutting forceps (Loewenberg, Schech, Mackenzie, Catti, Michael). It operates in a sagittal direction, and the two ring knives of the forceps cut the growths from behind forwards. The author claims to be able with this instrument to remove the growth in one sitting.

MICHAEL (Hamburg).

**FAUCHER.**—**Apparatus for Gaseous Injections.** *Gaz. des Hôp.,* June 4, 1887.

THIS apparatus consists of a large vessel in which is placed a packet of bicarbonate of soda, and which also receives the sulphuretted hydrogen. The flask is closed by a caoutchouc stopper, which is perforated by a movable tube; to this tube is suspended a reservoir, which is filled with sulphate of soda. When the tube is lowered, the reservoir is plunged into the liquid in the flask, and there is a liberation of gas. This is at once arrested by raising the reservoir out of the fluid, and "tuyant" the tube.

JOAL.

**BERGEON AND CORNIL.**—**Rectal Injections.** *Société Anatomique,* May 13, 1887.

A COMMUNICATION of the treatment of laryngeal and pulmonary tuberculosis by rectal injections of sulphuretted hydrogen. Last October, six rabbits were taken, and were rendered tuberculous by exposing them to inhalations and pulverizations of tubercular sputum. Three, taken as a control experiment, died in eight to ten days; the other three were submitted to rectal injections of two litres of carbonic acid gas charged with sulphuretted hydrogen, administered twice a day. The treatment lasted thirteen days. Amelioration was very rapid. On the thirteenth to the fourteenth day these rabbits regained their normal aspect. They were then killed, and though presenting the appearance of normal health, caseous nodules were found in the

lungs containing bacilli. The conclusion is that rectal injections of sulphuretted hydrogen transform what would be rapid lesions into conditions which advance slowly instead of quickly. JOAL.

**WOLFENDEN, R. NORRIS.**—Iodol: An Effective Substitute for Iodoform. *Practitioner*, vol. xxxviii., No. 5, 1887.

IODOL is very rich in iodine, containing only 7 per cent. less than iodoform, but parting with it more readily than the latter body. No toxic symptoms follow its constant use, and it is therefore preferable to iodoform on this account, and also because it is quite as effective, and further possesses neither smell nor taste. It is one of the best applications for ulcerations of the mouth, pharynx, larynx, and nose, ozæna, scrofulous ulcerations, specific conditions, &c. The author can confirm the statements of Lublinski, that the ulcers of phthisical laryngitis will heal completely under daily insufflations of iodol. The author uses the following preparations:—

1. Insufflations of the pure powder. It is more important to cover the diseased surface than to measure the dose.
2. Mazzoni's solution: Iodol, 1 part; alcohol, 16 parts; glycerine, 34 parts—a useful brush application, or coarse spray.
3. Iodol, 1 drachm; glycerine, 1 drachm; vaseline, 7 drachms—as a brush application.
4. Pastilles of iodol: Iodol, 1 grain; glycerine, 1 minim; glyco-gelatine, 18 grains. These are much preferable to iodoform pastilles and are the most serviceable of all for chronic pharyngeal conditions.
5. Iodol, 1 drachm; ether, 1 ounce—a spray or brush application.
6. Iodol bougies containing  $\frac{1}{2}$  grain iodol in each, for nasal conditions.
7. Iodol wool, 10 per cent. for tampons, &c.
8. Iodol gauze for dressings.

Iodol possesses all the properties of iodoform, is antiseptic, anæsthetic, a promoter of granulation and healing, arrests suppuration, and deodorizes foul secretions, and is to be preferred to iodoform on account of its pleasant and slight odour, and absence of taste. Its effects are quite as rapidly obtained.

**WAGNER, W. G.**—Direct Oxygenation in Croup as a Substitute for Tracheotomy. *Brit. Med. Jour.*, April 16, 1887.

IN cases where operation is declined, the required amount of respirable air may be supplied by generating oxygen and conducting it to a cone over the child's face. The relief afforded is equal to that of tracheotomy and oxygenation of the patient seems to lend strength to cast off the membrane.



**KUH, E. J.** (Chicago).—**The Etiology and Cure of Asthma.** *Journal of the Am. Med. Assoc.*, January 29, 1887.

DESCRIBES his own case, in which decided relief has followed the electric cauterization of the nasal mucous membrane. Gives a *résumé* of Hack's opinions, and says that after reading them, could bring on an attack of asthma by rubbing his ala nasi against the septum. Dr. Kuh takes occasion to remark, during the course of his article, that "it is as impossible to contract an acute bronchitis through temperature influences alone, as it is to contract tuberculosis through a cold." He is also of the opinion that "respiratory diseases are *inhaled*, not caught," and that the superstition of catching cold "is so pernicious because it diverts attention from the entrance-way of disease-generators."

J. N. MACKENZIE.

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## DIPHTHERIA.

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**SMITH, J. LEWIS** (New York).—**The Local Treatment of Diphtheria.** *Med. News*, April 9, 1887.

AFTER a short retrospect of the views for and against the local nature of diphtheria, Smith inclines to the belief in its constitutional origin, but insists on the importance of careful local treatment. The following solutions are recommended for use in spray or with a brush :—

- (1) R Acid carbolic, gtt. x.  
Liq. ferri subsulphate, ʒij.  
Glycerin, ʒij.  
M.

Dilute with equal quantity of water for use in spray.

- (2) R Aquæ chlorinæ, ʒj.  
Sodii bicarb., ʒss.  
Mellis } āā ʒss.  
Glycerin }  
Aq. calcis, ʒiv.  
M.

- (3) For nasal diphtheria :—

- R Acid boric., ʒij.  
Sodii borat., ʒij.  
Sodii chlorid., ʒj.  
Aq., Oj  
M.

And (4) R Acid boric., ʒj.  
Sodii borat., ʒij.  
Sodii chlorid., ʒiij.  
Aq., Oj.

M.

Smith has witnessed the employment of pilocarpine internally for its supposed local action in producing abundant mucous secretion and detachment of the membrane, with most disastrous consequences. The action of the heart became feeble, œdema of the lungs, with extreme dyspnœa, suddenly occurred, and the patient, who an hour before was in a comfortable state, perished from the pulmonary complication. The paper is well worth reading.

J. N. MACKENZIE.

**OWEN, EDMUND.**—Early Tracheotomy in Diphtheria. *Brit. Med. Jour.*, May 21, 1887.

At the Hospital for Sick Children, Great Ormond-street, in five years sixty-six tracheotomies have been performed, with twenty-five recoveries (*i.e.*, 38 per cent.). At St. Mary's Hospital during four years sixty-six cases have been operated on with twenty recoveries (30 per cent.). In the total cases, thus, were forty-five successful results = 34 per cent. In laryngeal diphtheria tracheotomy should not be regarded as a last resource, but as a most valuable therapeutic measure, if it only be performed early enough.

## TONSILS, PHARYNX, &c.

**BAKER, W. T.**—The Treatment of Tonsillitis. *Brit. Med. Jour.*, April 9, 1887.

A RECOMMENDATION of the local application of bicarbonate of soda. The tip of the finger is to be moistened, dipped into the powder, and rubbed gently over the tonsil, and repeated every five minutes for an hour, and then every hour for the rest of the day. Many patients entirely unable to swallow even liquids without acute suffering were in the course of an hour or two almost entirely free from pain. It is said by the author invariably to give relief even when suppuration seemed inevitable.

**GREEN, W. E.**—Remarks on the Treatment of Quinsy, especially in Infants. *Brit. Med. Jour.*, May 28, 1887.

THE author is of opinion that "one ought to be able to abort about

nine out of every ten cases" by the use of aconite. He relates the case of an infant aged eight months, in which  $1\frac{1}{2}$  minims of Tr. aconiti with 2 minims of Tr. guaiaci produced beneficial results.

GREVILLE MACDONALD.

**GORDON, N. R.** (Springfield, Ill.).—**Mouth-breathing and its Treatment.** *Jour. of Am. Med. Association*, April 23, 1887.

THE writer has found, in cases in which the nasal obstruction "is not indurated, fixed, or complete," a celluloid instrument devised by Fiber, of his native town, and so constructed as to fit nicely between the teeth and lips without the aid of bandages, a valuable agent in preventing oral respiration, especially during sleep. A cut of the instrument is given.

J. N. MACKENZIE.

**WELLS, E. F.**—**Erysipelas Developing in the Pharynx.** *New England Med. Monthly*, March, 1887.

NOTHING NEW.

J. N. MACKENZIE.

**LITTLEJOHN** (Edinburgh).—**Exhibition of the Gullet and Wind-pipe of a Man who had Swallowed a Quantity of Bow's Liniment.** *Before the Medico-Chirurgical Society of Edinburgh*, January 19, 1887.

MARKED evidence of intense irritation was present.

HUNTER MACKENZIE.

**WOLFENDEN, R. NORRIS.**—**A Case of Angioma of the Pharynx.** *Brit. Med. Jour.*, June 11, 1887.

THE patient was a young girl, aged twenty-five, of good general health, occupied as a nursery governess. What had attracted the attention of a suburban practitioner was a swelling in the front of the neck on the right side, about the level of the hyoid bone, and of the size of a hen's egg. This, however, gave rise to no inconvenience. It was soft, and was thought to be of lymphatic nature. Coursing through it could be felt some hard, cordy vessels. On the back of the neck, chiefly on the right side and at the level of the pharyngeal tumour, there was a collection of hard, superficial varicose veins. On illuminating the throat, a large angioma was seen to occupy the whole of the right side of the posterior wall of the pharynx, in the pharyngo-oral region. It appeared to spring from the posterior and lateral wall of the pharynx, behind the posterior faucial pillar, was considerably raised above the surface, and extended as far as the middle line of the pharynx. It was knotty, dense, and of purple colour. A small portion extended over to the left of the median line. Above, it reached to a little higher than the level of the

soft palate when raised on phonation ; below, the mass extended to the level of the base of the tongue, and, as far as could be seen, some varicose veins extended down towards the œsophagus. The tumour was thus of considerable size, and of remarkable appearance. The tonsils being very small, it was visible on simply opening the mouth. Some tortuous varicose vessels coursed along the right anterior faucial pillar and along the right side of the uvula. The most remarkable feature of this curious condition was that the patient had never suffered the slightest inconvenience from it. Just occasionally she had felt a "lump in the throat" when she had taken cold. Though the tumour encroached upon the lumen of the pharynx, there was no interference with swallowing. The patient was apparently unaware of the fact that she possessed this angioma, and the only history to be obtained was that the soft (? lymphatic) tumour in the front of the neck was first noticed when she was seven years old. Small angiomata, particularly about the base of the tongue and the larynx, are not infrequently met with. No such case as this, however, has been recorded, and the condition is probably quite unique. As the vascular tumour gave rise to no inconvenience, it was judged expedient, from its size and extent, to leave it untouched. A drawing of the pharynx accompanies the paper.

The author refers to Farlow's recent description of five cases of voluminous arteries (pulsatile and visible to the naked eye) of the posterior pharyngeal wall. Pulsating tumours of the pharynx have been observed by Porter and Syme, due to aneurysm of the internal carotid ; and Barnes has described a pharyngeal pulsating tumour which was arrested by applying pressure to the external carotid artery. Cresswell Baber has recently reported a case of pulsating artery on the posterior wall of the pharynx. It is probable that this condition is by no means rare, since it has been observed at the Throat Hospital in London at least twice during the last year.

**MASCHKA.**—*Forensic Casuistic.* *Prager Med. Wochensch.*, 1887, No. 19.

A WOMAN of twenty-nine years died suddenly in the street. She had only had for a day previously a slight redness of the tonsils. The post-mortem examination showed trachea and bronchi filled with a thick tubular membrane. Sudden death had occurred from stoppage of the bronchi.

MICHAEL.

## NOSE AND NASO-PHARYNX.

**BABER, CRESSWELL.**—On the Anterior Rhinoscopic View. *Revue de Laryngologie, &c.*, June, 1887.

A COMMUNICATION made to the Congress of Laryngology of the author's method of obtaining diagrammatic designs of the nasal fossæ.

JOAL.

**OBOLINSKI** (Krakau).—Plastic Operations for Deformed Noses. *Deutsch. Zeits. f. Chir.*, Bd. XXIV., Heft 1, 2.

THE original is illustrated, and the details cannot be understood without this. The author's success was good.

MICHAEL.

**WEIR.**—Injuries of the Nose and a Peculiar Bony Tumour of the Nose. *Med. News*, March 5, 1887.

1. A BOY fell a distance of four feet, flattening his nose by crushing in the cartilaginous septum. The nose was increased in breadth, sunken in, and the nasal processes of the superior maxillary bone were unduly prominent. Septum thickened but not deviated. Three days after the accident, Dr. Weir cut through from without the superior maxillary processes and forced them inward and toward each other, and held them *in situ* by a needle passed transversely across the nose, the ends of which were prevented from pressing against the skin by pads of iodoform gauze. At the tip of the nose, from within the nares, the thick skin was separated upward for a considerable distance by subcutaneous dissection from the cartilage, and pulled forward, and held by a silver wire clamped at each end with a shot over a little cork plate, so that the broad flattened under surface of the skin could be brought together. The upper pin was removed on the fourth day as sloughing was apprehended; this immediately ceased. The lower wire was kept in for twenty-four hours longer; no ulceration had taken place under the pads. Results excellent.

2. Plastic operation to replace the end of the nose, which was bitten off in a fight. 3. The long growth consisted of a greatly developed inferior turbinated bone, which was removed with forceps. The patient was a woman of twenty-two, who from her tenth year had suffered from obstruction of the right nostril, with which hemicrania had recently been associated. As nothing could be passed alongside the bony mass, it was decided, after the bone was exposed by the usual incision from the middle of the lip around the nose, to open the antrum. This cavity was free from disease.

J. N. MACKENZIE.



**STRONG, G. C.**—Nasal Catarrh and its Treatment. *Trans. Med. Soc. of Wisconsin*, 1886.

A résumé of the principal points connected with the subject, without original matter. J. N. MACKENZIE.

**MACDONNELL, R. C.** (Montreal).—Interstitial Nephritis, with Hypertrophy of the Heart, and Hæmorrhage into the Brain and Nasal Mucous Membrane. *Med. News*, January 15, 1887.

CLINICAL lecture containing original observation.

J. N. MACKENZIE.

**JOAL** (Mont Dore).—On Nasal Vertigo. *Memoir read at the French Congress of Laryngology, &c.*, 1887.

THE author states the following conclusions :—

1. There exists a nasal vertigo, a true *vertigo a naso læso*.
2. It belongs to the group of reflex vertigos, such as gastric, laryngeal, uterine vertigo.
3. Irritation of the trigeminal filaments innervating the mucosa of the turbinated bodies and the septum is the starting-point of the condition.
4. This irritation is transmitted to the vaso-motor nerves, through the sphenopalatine ganglion, whence arises circumscribed anæmia of the brain and vertigo.
5. The affections which give origin to vertigo are: (1) Nasal fluxions (odours, irritant vapours, snuff, flowering grasses); (2) Acute coryzas; (3) Chronic catarrh, especially the hypertrophic form; (4) Mucous polypi; (5) Post-nasal catarrh.
6. Vertigo is especially provoked by nasal affections of little importance.
7. The nasal reflexes are principally developed in arthritic individuals.
8. Vertigo can occur alone, or be accompanied by other nervous phenomena—troubles of vision, *muscæ volitantes*, hemicrania, nausea, vomitings, great excitability, hypochondria, intellectual disability, nightmares, spasmodic cough, dyspnœic crises, exaggerated secretions, syncope, feeble pulse, pallor of the face.
9. In order to establish the diagnosis the nasal fossæ should be examined in every individual suffering from vertigo.
10. The recognition of nasal vertigo will sensibly diminish the number of cases of gouty, rheumatic, anæmic, congestive vertigos, as well as cerebro-cardiac neuropathy.
- 11 Vertigo ceases with the cure of the nasal affection to which it owes its origin.

The condition has no connection whatever with Menière's disease,

and is independent of any affection of the ear. The author cites nine cases, on which, together with cases recorded by Massei, Guye, Gennaro, Hering, Hack, and others, his essay is founded. It is carefully written, and will well repay perusal.

**SEISS, R. W.—Thymol in the Treatment of Atrophic Nasal Catarrh.**

*Med. News, April 2, 1887.*

USES four solutions.

(1) Thymol, gr. ss.; alcoholis, ʒss.; glyc., ʒjss.; aq. dest., q.s., ad ʒj.

(2) Thymol, gr. jss.; alcohol, ʒjss.; glyc., ʒss.; aq., ad ʒj.

(3) Thymol, gr. v.; alcohol, glycerine, āā. ʒss.

(4) Twice the thymol strength of No. 3. Nos. 1 and 2 to be used in spray, 3 and 4 by means of cotton carrier.

The author describes the various forms of atrophy, dwelling particularly on the cirrhotic form or *rhinitis cirrhotica*, concerning the etiology of which he is substantially in accord with the views of the reviewer, published in a former number of the *Medical News*. (October 4, 1884.)

J. N. MACKENZIE.

**SCHIFFERS (Liege).—Treatment of Catarrh of the Maxillary Sinus.** *Rev. de Laryngologie, &c., June, 1887.*

A METHOD should be employed which will permit of medicaments being applied directly to the seat of the disease. This must be sought through the middle meatus, and it is possible to obtain the desired end without any need of practising perforation of the sinus by the alveolus. This is a surgical proceeding only to be resorted to in case the other fails, which indeed is exceptional.

A cannulated sound is introduced into the middle meatus to a depth of six centimètres beyond the ala of the nose, the latter being forcibly elevated; care is to be exercised in introducing the sound under slight pressure, and directing its inferior extremity towards the lateral wall. If the orifice is directed forwards, the sound penetrates readily; a fine stem is glided down the cannula, ending in a small button-like bistoury extremity, slightly concave (recalling an instrument often used to practise resection of the tonsils); one or two incisions are then made in order to open out the orifice.

Schiffers thinks that the nasal origin of this complaint is much more frequent than the dental.

JOAL.

## LARYNX.

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**BARBACCI, O.**—Experimental Contributions to the Physiology of the Superior Laryngeal Nerve. (Laboratorio di Patologia Sperimentale del Prof. Vulpian Sanzi). *Gazzetta degli Ospitali*, Anno viii., No. 24 and 25.

THE author affirms that his experiments do not pretend to be a control of the results obtained by Exner, which contradict the commonly accepted idea of Longet; nor does he feel authorized in drawing from them any general conclusions, but offers them as material that may ultimately be utilized by others. The experiments were performed on nine dogs. The first experiment tended to confirm the fact that the superior laryngeal contains only motor fibres for the crico-thyroid muscle. The 2nd, 3rd, 4th, 5th, and 6th experiments would indicate that section of the superior laryngeal nerve, at the end of ten, twelve, and even eighteen days, induces no degenerative lesions in the fibres of the crico-thyroid muscle, although they become paler and less vascular. With the 7th, 8th, and 9th experiments, the nerve filaments of all the muscles on the side operated on, show degenerating fibres, if we except those filaments which supply the crico-thyroid muscle. Nevertheless, adds the author, every time the superior laryngeal is stimulated, the crico-thyroid contracts energetically. He appears to think that the trophic influence is not supplied by the motor nerve; and that the median laryngeal, beyond its sensory function, may run with the fibres of the crico-thyroid muscle.

MASSEL.

**GAREL.**—Cysts of the Larynx. *Revue de Laryngologie, &c.*, June, 1887.

SCHWARTZ, in his recent book on tumours of the larynx, puts the proportion of laryngeal cysts at 3 per cent.; Garel, out of a total of sixty cases, has met with cysts of the larynx sixteen times, *i.e.*, 25 per cent.

In one case the cyst-wall was formed of epithelium after the Malpighian type; in two cases the tumours were sanguineous; in three cases the contents were concrete yellow masses,—these were epidermic cysts, the others belonged to the category of serous cysts. Of the sixteen cases, four were in women. Singing exercises seemed to have a large part in the etiology, since seven cases occurred in *artistes* and amateur singers. In the greater proportion

of cases, the tumours were situated towards the anterior third of the cords, ten times on the right vocal cord. All the cysts sprang from the upper or lower portion of the cords, not from the edge itself. In most cases there was absence of cough and expectoration.

On laryngoscopic examination the diagnosis of the fluid tumour is very easy, by reason of its opaline tint and the smooth, tense, rounded nature of the tumour. The diagnosis of blood-cysts is, on the contrary, almost impossible. JOAL.

**FLESCH** (Frankfort  $\circ$ /M.).—On the Frequency of Spasm of the Glottis, with a Special Report to Jürgensen's Text-Book of Special Pathology and Therapeutics. *Berl. Klin. Wochenschr.*, No. 13, 1887.

JÜRGENSEN says that he has never seen laryngismus stridulosus during a practice of twenty years. It is further remarked that in some countries this disease is very rare, while in others it is very common, and the remarks are reproduced of many authors who have made the same observation. MICHAEL.

**FEDE, Prof. F.**—Hydrocephalus; Spasm of the Glottis II *Morgagni*, November, December, 1886.

THIS is a clinical lecture on the case of a baby who at seven months began to suffer from convulsions and gastro-enteritic catarrh, and then from broncho-pneumonia and spasm of the glottis. The author discusses the clinical aspect and pathogenesis of spasm of the glottis, mentioning the various modes of origin. He does not adopt unreservedly the theory of Flesch, viz., of a reflex neurosis the result of faulty nutrition, but believes the causes are more complex. He considers that the spasm of the glottis is due to contraction of the adductors, and not to paralysis of the abductors, arguing from the tonic nature of the convulsions which accompany it. As to its etiology, spasm, whether produced by reflex action or by direct irritation of the central nuclei of the vagus, must nevertheless, as appears to him, always invoke reflex action. He considers that the secondary spasm, whether idiopathic or an expression of the general condition of the organism, may be congenital or acquired. Such condition induces at the same time rickets, with which it is often associated, as in the case in question. MASSEL.

**GERHARDT** (Berlin).—Paralysis Glottidis and Icterus. *Deutsch. Med. Wochenschr.*, No. 16, 1887.

IN two icteric patients the author observed hurried respirations (eighty to the minute) and aphonia. He believes that there is no similar case recorded of the connection between these symptoms, and is of opinion that this is a special disease. MICHAEL.

**FAUVEL.**—**Extirpation of the Larynx.** *Rev. de Laryngologie, &c.,* June, 1887.

THE author presented one of his patients to the Congress of Laryngology (see p. 266), on whom Péan had performed extirpation in 1885, leaving only the epiglottis and a portion of the arytenoids. Many foreign societies, and the medical press, have already commented upon this case. The patient has been able to return to his occupation of wine merchant. He succeeded in making himself understood by means of a feeble guttural sound, put into speech by means of the lips and mouth. His pronunciation could even be heard at a certain distance. None of the prothetic apparatus, sent from Berlin or Vienna, had succeeded in giving to the patient any substitute for his lost larynx. The patient preferred his own guttural sounds to any of these appliances. The operation is one of the greatest advances in surgery, and the conception is entirely due to the study of laryngology. The diagnosis of the case had been laryngeal syphilis.

JOAL.

**HERING.**—**The Surgical Treatment of Laryngeal Phthisis.** *Annales des Mal. du Larynx, March, 1887.*

A NUMBER of cases have been treated by the author with lactic acid, inhalations, "badigeonnages," sub-mucous injections, with or without scraping and excision. The following results have been arrived at :—

1. Eighteen patients, with infiltrations in all parts of the larynx, have been cured by the cleansing of the deeper and crateriform tumours. Cicatrization has been maintained for thirteen months, in spite of the total or partial destruction of the epiglottis.
2. Nine patients, at first cured, have had fresh attacks.
3. In six cases, of which four had pharyngeal tuberculosis, one a tubercular tumour of the nose, and one pulmonary tuberculosis, complete cicatrization was obtained after longer or shorter periods of treatment.
4. Fourteen cases have been treated by the surgical method, with good results. The author delays the publication of these results for the present.

JOAL.

**WHITEHEAD, W.**—**Tracheotomy.** *Lancet, April 30, 1887.*

THE operation proposed by the author is performed as follows. The head of the patient being bent well back over a pillow, an incision is made in the usual situation, but of rather greater length than is



common. The incision extends through the skin and fascia, as deep as the interval between the sterno-hyoid muscles. The scalpel is now laid aside, and the raspatory used, not only to separate the sterno-hyoids, but to split the strong fascia which runs down from the hyoid bone to enclose the isthmus of the thyroid gland. This fascia is split to a distance extending from the upper limit of the incision down to the isthmus below—that is, supposing it is desired to open the trachea above the isthmus. The split fascia is then pushed to right and left with the raspatory. Should there be any difficulty in doing this, the fascia is separated to some extent on each side from the upper border of the isthmus. Proceeding carefully, the isthmus itself can be pushed down, and the trachea exposed to the necessary extent. If the trachea is to be opened below the isthmus we proceed in a similar manner, remembering that here, however, we have between the fascia and the trachea a quantity of areolar tissue in which lies the inferior thyroid plexus of veins. The front of the trachea can in this way be cleared perfectly, and, since the method is bloodless, the rings of the tube are seen glistening white at the bottom of the wound. The trachea can now be fixed readily between the left index finger and thumb, and opened to the desired extent. There is little or no difficulty in introducing the cannula, since the trachea can be so steadily fixed and the incision into it so clearly seen.

The above method resembles in many particulars the “bloodless” method of Bose, but in the latter operation the scalpel is used to a much greater extent than in the operation here advocated, and when the scalpel is not to be used the employment of the director is advised. But the walls of the veins in this region are very thin, and the sharp edges and point of the director have been frequently known to tear these vessels and rob the operation of its bloodless character. This tearing of the veins is much less likely to occur if the raspatory is used. Moreover, the above operation with the raspatory is not only suitable for cases where the surgeon has abundant time at his disposal, but is advised even in emergency tracheotomy; since, although perhaps a little more time is required to reach the trachea, the certainty that when once reached it can be quickly opened and entered is a distinct ultimate gain. What is urged in favour of the operation is—firstly, the ease with which it can be performed; secondly, the small number of instruments required; and, thirdly, the manner in which it meets the four difficulties usually enumerated—viz., of reaching the trachea, of hæmorrhage, of opening the trachea, and of introducing the cannula. Again, it avoids, in an especial manner, those dangers met with when the operation is per-

formed, as it too often is, practically in the dark, from the bleeding, and the not sufficient separation of the parts; thus it is impossible, in this operation, that the cannula should be pushed down between the trachea and the fascia lying in front of it, or that it should be thrust, as has actually happened, into the internal jugular vein.

**RENTON** (Glasgow).—**Tracheotomy.** *Glasgow Medical Journal*, October, 1886.

DESCRIPTION to the Glasgow Medico-Chirurgical Society of a Case of Tracheotomy in a Child, in which the operator removed a brooch-pin which was lying between the trachea and the œsophagus. There had been an abscess, which had burst. HUNTER MACKENZIE.

**STEWART, W. R. H.**—**Case of Thyrotomy for Epithelioma of the Larynx.** *Lancet*, May 21, 1887.

THE thyroid cartilage having been divided in the middle line, the tumour and vocal cord were cut away with curved scissors, and the remains scraped with a sharp spoon and cauterized with nitrate of silver. The wound healed well. At the end of four weeks the patient was lost sight of; so that the case falls short of being instructive. GREVILLE MACDONALD.

**PATERSON and NEWMAN** (Glasgow).—**Gunshot Wound of the Larynx.** *British Medical Journal*, October, 1886. Exhibition of Case before the Glasgow Clinical and Pathological Society.

A SPLINTER of ball had been removed by Newman from the larynx by the endo-laryngeal method. HUNTER MACKENZIE.

**MACLAREN** (Edinburgh).—**Larynx and Trachea from a Case of Burning.** *Edinburgh Medical Journal*, October, 1886.

DEMONSTRATIONS of Specimens before the Medico-Chirurgical Society of Edinburgh, June, 1886. HUNTER MACKENZIE.

**BASSOLS Y PRIM.**—**On Stammering.** *Anales de Otología y Laryngología*, Ano. V., No. 1. *Alcalá de Henares*.

AFTER giving a summary of the causes, symptoms, diagnosis, and treatment of stammering, the author publishes a case of cure in a youth twenty years old, who had been a stutterer since his sixth year, without any lesion whatever in the organs of phonation or speech. His stammering was specially manifested in the explosive consonants, when he was roused, and while reading. The cure was effected in a month by using a series of graduated exercises, and by practising gymnastics of respiration, voice and the mouth.

RAMON DE LA SOTA.

## NECK, &c.

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**SLOAN, A. T.**—**Goître in Animals.** *Lancet*, May 28, 1887.

THE author enumerates the various animals that are known to be liable to the disease. In some localities it is more common in mules and horses than in men. In three cases in horses the enlarged thyroid has induced compression of the trachea. It appears to be specially prevalent among mules, and the author remarks on sterility being one of the characteristics of cretinism. He concludes with some remarks on the artificial production of goître in animals, but judges that the results are not of much value.

GREVILLE MACDONALD.

**AIGRE** (Boulogne).—**Tumour of the Thyroid Gland.** *Revue de Laryngologie, &c.*, June, 1887.

THE tumour occurred in an aged patient, and was of cancerous nature. The author makes the following remarks :—

Malignant tumours of the thyroid gland are tolerably rare. Since 1882, only seven cases have been published ; in none of these cases is there any history of those early acute pains, radiating into the neck and arm, of which authors repeatedly speak of as characteristic. Cachexia is also rare, and in the cases recorded the patients died from dyspnoea, dysphagia, hæmorrhage, and chronic nephritis. The cancerous mass, instead of being propagated along the cellular tract, which is plentiful in this region, is directed at first from before backwards, pushing on one side the large vessels and nerves, reaching the sides of the trachea and œsophagus, then enclosing the latter structure so as to meet the opposite thyroid lobe.

Obliteration of the jugular vein is a frequent occurrence, but no phenomena of cerebral stasis are recorded, the anterior jugular and vertebral veins compensating for the closure. There is not, however, any abnormal development of these compensatory veins.

An important point also is the slight alteration of the voice, notwithstanding that at the autopsy one may search in vain for traces of the recurrent nerves.

JOAL.

**ALBARRAN** (Barcelona).—**Primary Carcinoma of the Œsophagus.** *Gaceta Médica Catalana*, No. xxiii., Ano. 80.

OBSERVATION of a case of primary carcinoma of the œsophagus, the inferior half of which was the seat of a whitish, friable, pendulous growth, extending to the cardia, and invading the stomach to the extent of from seven to eight centimètres. In the posterior part of

the œsophagus, at about six centimètres from the cardia, there was a perforation three centimètres in length and two in width. The bottom of this perforation was formed by the prevertebral cellular tissue, which replaced the wall of the œsophagus at this spot.

Histological examination showed the disease to be an encephaloid carcinoma. The peculiarity of this case consisted in the fact that the patient had another tumour of similar nature in the upper jaw. Albarran did not think gastrotomy feasible, the operation itself being unfavourable, and there was in this case every probability, from the patient's enfeebled condition, of the worst results from operating.

RAMON DE LA SOTA.

**BIRD, GOLDING.**—Gastrotomy for Epithelioma of Œsophagus; Immediate Feeding by Puncture of Stomach; Death after Six Hours. *Brit. Med. Jour.*, May 21, 1887.

A SPECIAL point brought out in this case is the advantage of employing a pointed cannula as a means of immediately introducing a liquid meal. No regurgitation through the puncture occurred on withdrawing the cannula, and when the stomach was opened with a knife, four hours later, the puncture was only visible as a small hæmorrhagic spot.

**TAYLOR, H.**—Parotitis after Injury or Disease of the Abdomen or Pelvis. *Brit. Med. Jour.*, April 16, 1886.

A CASE in which the author thinks that an attack of parotitis followed wounding of the seminal vesicles during an operation for imperforate anus upon an infant.

**CHURCH, H. M.** (Edinburgh).—On a Case of Poisoning by Corrosive Sublimate. *Edin. Med. Jour.*, March, 1887.

THE points of interest to the reader of this Journal were, the swelling of the lips and cheek, the presence of pain in the throat, the absence of salivation, and a profuse mucous discharge from the nose. The patient (a girl of five years, who had had administered to her by mistake a glycerine solution of corrosive sublimate instead of castor oil) died within twenty-three hours. Necropsy showed lips livid; gums white; sordes on upper incisors; grumous mucus escaping from nostrils; tongue sodden; pharynx presenting a general diphtheritic look; gullet distended. To within one inch of its upper extremity, the œsophagus presented a yellowish-grey appearance. Above this there was much congestion, which became marked over each tonsil and on either side of the rima glottidis. Grey patches of a diphtheritic nature covered the fauces. The trachea was markedly, and the larynx moderately, congested. The writer attributes death partly



to the primary corroding action of the poison upon the tissues. (It is a matter of general interest to know that no traces of mercury were found by a chemical expert in the organs, tissues, or secretions.)

HUNTER MACKENZIE.

**SINCLAIR, A. J.** (Edinburgh).—**Case of Phosphorus Poisoning.**  
*Edin. Med. Jour., March, 1887.*

A CHILD, aged twenty-two months, had sucked some phosphorus matches, traces of which were found in her mouth and on her lips. When the writer attended he found the cheeks red and flushed, and a dark treacle-like fluid was occasionally vomited. White-coloured fumes emanated from the mouth (after the administration of the white of an egg with flour). Death took place in about six hours. No necropsy was permitted. Neither the stools nor the vomited matter showed any traces of phosphorescence.

HUNTER MACKENZIE.

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## ASSOCIATION AND CONGRESS MEETINGS.

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### The French Society of Otology and Laryngology.

ON April 13, 1887, M. MENIÈRE opened the meeting, ceding the chair to M. GOUGENHEIM, the newly-elected president. The bureau was constituted as already reported (this Journal, May, 1887). The following papers of laryngological interest were read :—

1. *Case of Hemorrhagic Laryngitis.* By Dr. GAREL. (An abstract of this paper has already appeared in this Journal, *vide* p. 222.)

M. POYET questioned whether the case was really one of hæmorrhagic laryngitis. M. Garel merely stated on the part of the larynx, rupture of vessels, lesions of the mucosa, and violent cough, which had determined the flow of blood. But besides this, M. Garel admitted a grave cardiac and vascular condition, which might of itself be the primary cause of the disseminated hæmorrhages, and the blood might have coagulated in the larynx. M. Poyet regarded the hæmorrhage as the result of a diapedesis, and not of a laryngitis. Strübing, in his observations, says that the reddened and inflamed vocal cords present blackened points where the flow of blood had occurred.

M. DELIE agreed with his colleague Poyet. There was in this case a general condition dominating the laryngitis, which was only secondary. He could not see that the larynx of the patient presented any degeneration of the mucous membrane. "I cannot," said Delie, "understand the case enunciated by our estimable confrère as one falling under the category of hæmorrhagic laryngitis. It is essential not to confound hæmorrhages, or sanguineous transudations, manifested in all organs under conditions of profound alterations of the blood, with inflammations of the larynx sufficiently violent to lead to a local rupture, either superficial or deep, of the laryngeal arteries. The clots of blood met with on, or between, the vocal



cords in patients who expectorate blood, and who are subjects of chronic albuminuria, cirrhosis, scurvy, etc., proceed from the deeper portions of the respiratory passages; the blood is arrested in its passage, and during sleep and the consequent repose of the larynx, it collects on the free edge and inferior surface of the vocal cords. In the majority of cases the sanguineous transudation is minimal at the surface of the laryngeal mucosa."

M. MOURE thought that the hæmorrhage in Garel's case was as much laryngeal as tracheal, nasal, etc., and the clots were fixed on the vocal cords just as they were formed in the nasal fossæ. He cited the case of a singer who had ruptured a vessel during a vocal effort. On laryngoscopic examination Moure found a true hæmorrhage from the upper surface of the left vocal cord, the mucosa being red and ecchymotic. In another case laryngeal hæmorrhage was produced after the use of alum pulverizations.

M. MOURA thought that the existence of a hæmorrhagic laryngitis could not be affirmed from the simple occurrence of clots in the various regions of the larynx. Before this could be done, the site of the lesion giving origin to the blood must be determined, and the larynx must first be cleared of all clots. He had seen two cases of hæmorrhagic laryngitis; in one, the blood flowed, or rather trickled, from the left ventricle; and in the other, from a deep ulceration, which, after having destroyed the mucosa, had attacked the thyroid cartilage immediately below the commissure of the lips of the glottis.

M. JOAL did not believe that the term hæmorrhagic laryngitis should be applied to Garel's case. The very term laryngitis presupposes inflammatory conditions, with vascular rupture and ecchymotic spots, such as are seen in singers after great vocal efforts. In the case related there was a general condition, and the hæmorrhage was not the consequence of inflammation.

M. VACHER thought that under the term laryngeal hæmorrhage, or hæmorrhagic laryngitis, should be meant a typical local condition. On the other hand, he could not see how, according to Moura, one could be assured of the state of the larynx when this was covered with adherent clots; and to provoke the expulsion of these clots, or to remove them, appeared to him to be a dangerous proceeding.

M. GAREL answered, regarding his case as a veritable hæmorrhagic laryngitis, since the issue of the blood clearly took place at the level of the larynx, not only on the vocal cords, but on the mucosa of the arytenoids, and the epiglottis. After the disappearance of these clots, he was able to state opaline marblings over the points previously occupied by them. While admitting that hæmorrhages can be observed to occur from the larynx after vocal efforts, in the course of acute laryngitis, attacks of whooping cough, etc., most frequently these are hæmorrhages which do not possess the aggregate of symptoms remarked by himself, and which do not last long. The influence of the vascular state of the individual should be considered in the same line as the hæmorrhagic laryngitis; the other cases deserve only the term "hæmorrhage from the larynx."

2. *The Treatment of Catarrh of the Maxillary Sinus.* By DR. SCHIFFERS (of Liege). (This paper is abstracted at p. 253 of this Journal.)

M. BARATOUX believed that the condition was most frequently due to dental caries.

M. CHATELLIER thought it could not always be attributed to dental caries. He recently made an autopsy upon a patient who had died from pericarditis with effusion, and who had been the subject of an *ozæna* emitting a repulsive odour. At the autopsy was found an increased roominess of the nasal fossæ, small inferior turbinates, and the left antrum of Highmore, with the sphenoidal sinus full of

pus, without, however, having any odour like *ozæna*. There was no ulceration in the nasal fossæ.

M. NOQUET thought that catarrh of the maxillary sinus might be consecutive to an inflammation of the nasal mucosa; but was oftenest provoked by dento-alveolar lesions. He had seen during the last year one case in which it sufficed to extract a very carious molar in order to obtain evacuation of the sinus. The patient was rapidly cured by antiseptic injections made through the aperture.

M. GAREL had treated a case of nasal obstruction from polypi, with infectious suppuration. Suppuration was arrested after the extraction of a carious tooth.

M. BOUCHERON related the history of Louis XIV., who was afflicted with a suppurating dental caries, and for which his surgeon successfully employed the hot iron. He had also published a case of extensive malformation of the palatine arch due to old inflammation of the maxillary sinus; the inflammation had formed an enormous cyst, which had displaced the floor of the nasal fossæ from the arch of the palate. The cyst was opened.

M. GELLÉ thought that sometimes the dental origin was undeniable, and these were the ordinary cases. Sometimes the origin was prosthetic apparatus, as he had observed in one case, and the operations necessitated by dental caries when they are multiple.

M. VACHER thought that inflammation of the antrum of Highmore might be caused by violent coryzas.

M. POYET found that irrigation of the sinus is more easily performed through the maxillary opening than through the nasal meatus.

M. SCHIFFERS did not contest the dental origin of the condition, but the question to be decided is whether the nasal origin is not the most frequent. He thought that this latter was the case, considering the frequency of dental caries and the rarity of its complication with inflammation of the sinus. The foetid odour exhaled by the patient is not a sign of this inflammation, it may proceed from the mouth alone; the pus may also have its origin solely in the alveolus. The necessity of a rhinoscopic examination is to be insisted on for the purpose of diagnosis. The purulent stream issues out of the middle meatus; it is unilateral and intermittent. It is evident that when dental caries is pronounced and osteoperiostitis exists, surgical opening through the alveolus is indicated. It may occur spontaneously.

M. BARATOUX had observed thirteen cases of inflammation of the sinus and had stated the presence of purulent concretions at the level of the antrum of Highmore. Dentists habitually treat such cases by removing the carious roots, and washing out the sinus by injections through the perforated alveoli, and they cure their patients very well.

M. GOUGENHEIM believed that Schiffers had attributed to rhinitis an excessive influence in the production of catarrhs of the maxillary sinus. That dental affections play an important part in the production of these affections is well known to dentists. A certain number of such cases escape throat and nose specialists.

*Meeting of 14th April.*

3. *On Supplementary Glottides.* By M. GOUGENHEIM. (To be abstracted in next number.)

M. MOURE observed that the title of this paper should have been "Supplementary Vocal Cords," not "Glottides," the glottis being a space comprised between the true vocal cords, and not being able to give rise to vibrations. "We have all had occasion," said he, "to observe patients like those spoken of by Gougenheim. Many times I have met with patients who, having no vocal cords, were able to speak by means of the ventricular bands supplementing, in a certain fashion, the true lips of the glottis. The voice was rough, but sonorous."

M. MOURA remarked that cases often occurred in which the superior bands, and even cicatricial productions permitted of speech in the absence of true vocal cords, but the voice is no longer able to modify sounds in an ascending and descending manner. These false cords are capable of vibration, but they give to the voice a low timbre. Their vibrations are always "vibrations d'emprunt."

M. VACHIER understood under the term glottis, not only the space between, but also the free edges of the vocal cords. He cannot admit that they can be supplemented as vibrating and sonorous cords.

M. GOUGENHEIM said that in the case described by him, he had observed the gamma ascend through the range of an octave. It seemed to him inadmissible that the superior vocal cords could have by their vibrations engendered the sounds produced, in this case. He admitted that bruits could be emitted by parts of the larynx other than the inferior vocal cords, but could not accept the view of Joal and Moure, that the upper musical notes of the voice could be attributed to the action of a deformed organ only able to give origin to unformed sounds.

M. JOAL admitted with Moure that the superior bands could vibrate in certain circumstances, although the inferior bands were destroyed. Patients whose vocal cords are destroyed by syphilis or tubercle will sometimes produce vocal sounds by the approximation of the superior vocal cords. He had recently observed this in a patient whose true vocal cords were totally destroyed. When there was no inflammation the voice was very deep; when there were acute phenomena, he spoke with a falsetto voice. During phonation the superior vocal cords approximated.

4. *Classification of the Laryngeal Muscles.* By M. MOURA. (This paper is not yet published.)
5. *Indurated Chancre of the Right Nasal Fossa.* By M. MOURE (of Bordeaux). (This paper is not yet published.)
6. *Tumour of the Thyroid.* By Dr. AIGRE. (See this Journal, p. 259.)
7. *Presentation of an Instrument for Scarification of the Vocal Cords.* By M. GAREL.

*Meeting, April 15, 1887.*

8. *Atrophic Rhinitis.* By M. NOQUET (of Lille). (See this Journal, p. 214.)

M. CHATELLIER thought that the term atrophic rhinitis should be rejected, since it expresses a false idea of the nature of ozæna. The partisans of this pathological idea themselves admit that the atrophic period is preceded by a phase of hypertrophy. But histological research proves that the tissue which constitutes pituitary hypertrophy has no tendency to atrophy; it resembles mucous tissue; one even finds mucous tissue with evident infiltration with mucin, easily demonstrated by histo-chemical reactions. The mucous tissue does not atrophy; quite the contrary.

M. MOURE replied that there is not only atrophy of the mucosa but of the turbinated bodies.

M. GELLÉ said that the detailed exposition given by Chatellier of lesions of the mucosa left quite inexplicable the remarkable atrophy of the osseous portions of the turbinated bodies.

M. CHATELLIER replied that this atrophy proceeded from a rarefying osteitis.

M. GELLÉ did not see the necessity for admitting an osteitis. He thought that the nutrition of the bone suffered a grave alteration in nutrition consecutive to a lesion, or parallel with the evolution of lesions of the submucous periostitis, which is not sufficiently insisted upon. A slow atrophy is there produced by arrest or insufficiency of nutrition.

M. CHATELLIER remarked that pathological anatomy has taught us that

portions of the skeleton can be arrested more or less completely in their development at variable periods in the growth of young subjects, and that bones symmetrically placed may, at the end of a certain time, have an unequal volume as regards one another, or both may be inferior in volume to the normal condition. But atrophy, or absorption of bone, is a fact of which there does not exist any example in the economy. Why admit that the nose is an exception to the general rule, and that one portion of the skeleton is susceptible of atrophy, after having acquired and preserved a normal volume for some time? M. Chatellier rapidly reviewed the condition known as rarefying osteitis, a condition which could not be regarded as explanatory of the disappearance of the turbinated bodies. This atrophy of the turbinated bones and mucosa, has never been demonstrated either by observation or pathological anatomy, and is opposed to what we know of the pathological anatomy of osseous tissue. He further thought that before affirming the fact of the diminution of a bone (turbinated), irrefutable proof should be advanced of the fact. M. Chatellier has no knowledge of the theory of Fraenkel, referred to by M. Moure, as establishing anatomically turbinated atrophy.

M. RUAULT referred to the micrococcus theory of Loewenberg, cited by Noquet, which attributes to micro-organisms of large dimensions the phenomena of ozæna, the organism when grown in gelatine being said to give to the cultures the odour of ozæna. Loewenberg's work did not seem to have sufficiently attracted attention. It required repetition, and if confirmed was a fact of the highest importance, the ozæna being the symptom which caused the patient most trouble, and if definitely proved to be due to a micro-organism one might hope to find some means of combatting it. Since ordinary antiseptic irrigations do not effect a cure, it would not be unreasonable to suppose that the organism existed in the tissues in larger or smaller quantity, and being prolonged on to the mucous surface (by reason of its great length) re-infected the surface continually. The same kind of thing is observed in the gonococci which inhabit excretory canals of the glands of Bartholin, and keep up a constant blenorragia. Ozæna accompanied with dryness of the nasal mucosa often becomes spontaneously cured. Such cases are frequently met with in young girls, more frequently than would be supposed. The determination of the origin of the odour is a factor of prime importance, and no sufficient explanation has yet been advanced. It is certainly not due to deficiency of expiratory current through enlargement of the nasal fossæ, with consequent accumulation of secretions and putrid degeneration, as suggested by Lantal, else all patients who suffer from naso-pharyngeal obstruction and respire through the mouth should have ozæna. In such patients dry crusts are found, but without odour. The opinion of Krause that ozæna is due to fatty degeneration of the mucous cells with consecutive development of volatile fatty acids is less satisfactory than the microbe theory of Loewenberg. There is no proof that ozæna may not be contagious under certain conditions.

M. BARATOUX admits that ozæna may be the result of absence or arrest of development of the turbinated bodies, or of atrophy of the nasal mucosa. At the recent Berlin Congress, Habermann read a memoir in which he sought to establish that ozæna commenced at the surface of the mucosa—i.e., at the orifices of the glands. Baratoux thought this form susceptible of cure, having observed many cases in which the turbinated bodies had recovered their normal condition.

M. NOQUET recognized the importance of Chatellier's microscopic researches. His own remarks were entirely based on clinical experience. What he wished to establish, was that in three cases the atrophied mucous membrane had been regenerated, and the odour had completely disappeared. He could not say if a hypertrophic stage existed, but was disposed to admit it. When competent observers like Moure and Bayer affirm its existence, we must believe them.



M. MOURE had only given his opinion with extreme reserve that atrophied turbinated bodies were regenerated; in every case this structural modification is only obtained after very prolonged and persevering treatment.

M. MIOT did not believe in a hypertrophic stage of the complaint. He had during some years watched a child six months of age, who had smooth, thin mucosa over the inferior turbinated bodies. The nasal fossæ developed, but the inferior turbinated bodies preserved their small contour. This child would probably eventually suffer from ozæna.

9. *On the Lymphatics of the Larynx.* By M. POIRIER (of Paris).

THE author exhibited two large diagrams, tracing the lymphatics of the inferior aspect of the glottis to a subcutaneous gland and passing through the crico-thyroid ligament.

10. *Cysts of the Larynx.* By M. GAREL (of Lyons). (This paper is abstracted at p. 254.)

M. RUAULT remarked that on some of the drawings presented by M. Garel in explanation of his paper, the appearance of the tumours of the inferior vocal cords is apparently identical with that of the small myxomata sometimes seen there. It would be impossible to establish the diagnosis if the tumour were crushed in the forceps, for the crushing would cause the protrusion of a drop of liquid just like a small cyst.

M. GAREL said he had been fortunate enough to meet with a number of cases, and had not only seen the liquid escape from the cyst, but had been able to demonstrate the nature of the tumour microscopically.

11. *The Treatment of Laryngeal Tuberculosis.* By M. HERING (of Warsaw). (This paper is abstracted at p. 256.)

M. GOUGENHEIM presented, on behalf of the author, a number of drawings and a photograph, showing cicatrices of the laryngeal lesions, curettes, scarifiers, hypodermic syringes, etc., for the lactic acid treatment.

12. *On the Anterior Rhinoscopic View.* By CRESSWELL BABER (of Brighton). (See p. 251.)

13. *On Extirpation of the Larynx.* By Dr. CH. FAUVEL (of Paris). (See p. 256.)

14. *On Nasal Vertigo.* By M. JOAL (of Mont Dore). (See p. 252.)

M. RUAULT recognized that in one of the cases related by Joal the nasal origin of the vertigo seemed indisputable. One could not only produce vertigo by touching the least permeable portion of the posterior part of the nasal fossæ with a sound, but a cure was effected by removing the hypertrophied portions by means of the galvano-cautery.

M. GELLÉ, without refusing to admit the evident etiology of the vertigo in Joal's observations, drew attention to the modifications and alterations of the static and dynamic conditions of the ear by naso-pharyngeal affections, apparently of the slightest nature. By means of centripetal pressures he had been able to provoke vertigo each time, and thus to affirm its evident auricular origin, when the absence of auditory trouble, and the excellence of the auditory function, seemed to point to any origin rather than auricular.

M. RUAULT said that he had not tried to produce auditory vertigo in the manner indicated by M. Gellé. It is possible to do so, but that would not prove the auricular origin of spontaneous vertigo, whilst the cure of the complaint after the disappearance of the nasal condition clearly showed it to be of nasal origin.

[From the *Compte Rendu Officiel de la Société Française d'Otologie et de Laryngologie.*]

JOAL.



## REPORTS OF SOCIETIES.

### Berlin Medical Society.

*May 11, 1887; May 18, 1887.*

B. FRÄNKEL demonstrated a specimen of œdema glottidis. The patient had great dyspnea for an hour. The laryngoscope showed œdema glottidis. The patient died before tracheotomy could be performed. The author believes that the œdema owed its origin to chronic kidney disease, which was found on post-mortem examination.

VIRCHOW asked if there was any examination made for the erysipelas coccus.

At the next meeting Fränkell stated that there was no erysipelas coccus, but that in the larynx there was found an inflammatory condition which might have been the cause of the œdema.

LUBLINSKI showed a woman with carcinoma œsophagi, beginning behind the left arytenoid. An operation would be performed. MICHAEL.

### Congress of German Surgeons.

*April 15, 1887.*

WÖFLER (Graz): *On the Effect of the Ligature of the Thyroid Artery on Goitre.*—The author had made experiments on the ligature of the arterie thyroidie, with the result that it was possible to supplant this operation for extirpation of the goitre.

EUGEN HAHN (Berlin) demonstrated a method of operating on the goitre without loss of blood. He ligatures the arteries and compresses them. The gland is then bloodless, and portions of it can be removed. MICHAEL.

### Royal Society of Physicians in Budapesth.

*April 30, 1887.*

Dr. JELENY demonstrated a nasal speculum which could be opened and closed with one hand. MICHAEL.

### British Medical Association.—South Indian Branch.

*December 5, 1886.*

*Fibro-Cystic Bronchocele.*—A paper by Surgeon J. SMYTHE, on a case of fibro-cystic bronchocele was read. The patient was a woman, aged thirty; the cysts were evacuated through a cannula, and a solution of perchloride of iron, made by adding two drachms of the tincture to an ounce of water, was injected. Considerable local inflammation resulted, and there was some constitutional disturbance, the temperature running up to 103.4° F. A small cyst which appeared to develop after the operation was injected at a later date, and the final result was very satisfactory, the circumference of the neck being reduced from 18½ inches to 13½ inches.

Mr. BRANFOT expressed the opinion that free incision and drainage was the best way of treating cystic bronchocele if not very vascular.

Mr. DRAKE-BROCKMAN thought that the fever which followed the operation might have been partly due to the strong injection used.

*February 4, 1887.*

*Distension of Antrum of Highmore.*—A case of distension of the antrum of Highmore, with great hypertrophy of its walls, was contributed by Surgeon J. SMYTHE. The patient was a male Hindu, aged thirty; the hypertrophic

condition affected the nasal bones and the malar bone of the corresponding side, and as was shown by a drawing, produced great deformity. An operation was performed, the anterior wall of the antrum being taken away, and the deformity thus diminished.

Mr. DRAKE-BROCKMAN thought that the swelling was probably due to a solid fibroid tumour which had undergone degeneration, and had led to a secondary thickening of the bones.

Mr. SIBTHORPE coincided.

### British Medical Association.—Oxford District Branch.

*April 27, 1887.*

*Intubation of the Œsophagus.*—Mr. G. H. RODMAN read a paper on intubation of the œsophagus as an alternative to gastrostomy, in which he said that statistics did not show very satisfactory results from gastrostomy. Full details regarding intubation were given, and three cases in which it had been tried were referred to. One of these was shown; the patient, who had been admitted in a starving condition, had gained 1 stone  $3\frac{1}{2}$  lbs. in twelve days.

### Cambridge Medical Society.

*February 4, 1887.*

*Quinsy.*—Dr. EASBY (Peterborough) read a paper on quinsy and its treatment. After speaking of the old method of antimonials, free purgation, complicated gargles, leeches and blisters, Dr. Easby advised the use of aconite given after Dr. Ringer's method, or from ten to fifteen grains of salicylic acid or salicylate of soda given every two hours, which had invariably afforded speedy relief. Gargles were strongly condemned as both useless and cruel to the patient. As a local application, a powder consisting of equal parts of tannin and iodoform puffed on to the swollen tonsils he had found give great relief to the pain.

Dr. LATHAM agreed that gargles were useless, and advised the use of the spray, chlorine water, or some antiseptic. It was especially useful for children. He strongly endorsed Dr. Easby's remarks on giving salicylic acid and salicylate of soda in the early stage, more especially if there was any association of rheumatic symptoms.

*Note on Stellwag's Symptom.*—Mr. WHERRY showed a patient, a married woman, aged thirty-two, who came to Addenbrooke's Hospital, with marked retraction of the left upper eyelid (Stellwag's sign). There was no proptosis or goitre, but some throbbing of the carotids and palpitations; no cardiac bruit. She blushed and perspired very easily, and suffered a good deal from indigestion and sleeplessness. The retraction of the lid was extremely well seen when the eyes looked downwards. There was no want of consensual downward movement of the eyelid (Graefe's sign). The pupils were equal and active,  $V=\frac{2}{3}$  in both; fundus normal; no pulsation in the retinal vessels; complete power of closing the eyelid; cornea and conjunctiva sensitive. The patient has been married thirteen years; had no miscarriage; has one child, now six years old; has had no illness of late; menstruation quite regular, rather scanty; occasional leucorrhœa. Although there was no exophthalmos or goitre, Mr. Wherry thought this was probably a case of Graves' disease. This patient had first noticed something wrong with her eye about a year ago. She had been under observation for the last six months, and had improved under treatment by bromide draughts at night, and small doses of belladonna twice daily. There was little change, however, in the eyelid symptom, which came on rather suddenly and continued to the present. Mr. Wherry wished to draw attention to this symptom without suggesting any theory as to the pathology of Graves' disease, because the opinion has been expressed by

Graefe that cases are not rare in which the only symptoms of this affection in women are rapid action of the heart without hypertrophy or valvular disease and defective mobility of the lid; the latter is, at any rate, an extremely important symptom to take note of—important in the diagnosis, treatment, and pathology of Graves' disease.

**Pathological Society of London.**

*April 5, 1887.*

*Alveolar Ulceration and General Tuberculosis.*—Mr. JONATHAN HUTCHINSON, jun., showed some specimens obtained from a child aged two years, who died while under the care of Dr. Stephen Mackenzie. It was uncertain whether any causal relation existed between the stomatitis and the tuberculosis, as the latter was a rare complication, nearly all the cases of ulcerative stomatitis in children recovering under the use of chlorate of potash or other treatment. Nor did sections of the affected gums and lip show tubercle bacilli or any tuberculous structure. The surface of the ulcers was ragged, and for a varying depth was in a necrotic condition, the structures being ill-defined and not staining well. In the lip the muscular bundles next the surface were matted together, and the striation was indistinct. Micrococci were plentiful in this layer, but the long bacilli found by Lingard and Batt in ulcerative stomatitis of calves and in a case of noma were not present. Under the necrotic layer there was considerable inflammatory cell-effusion. It was stated that ulcerative stomatitis of children could be inoculated (Bergeron), but the microscopical appearances would confirm the clinical evidence that this disease was quite distinct from noma and from the ulcerative stomatitis of calves and other young animals.

Mr. F. TREVES said that there were many arguments in favour of the suggestion that the ulcerated tongue was the seat of inoculation of tubercle.

A case of *Hypertrophic Goitre with Secondary Tumours in the Skull* was introduced by Dr. JOSEPH COATS. The thyroid gland presented considerable enlargement of both lobes. The tissue of the enlarged gland was that of ordinary goitre—namely, greatly multiplied saccules, with occasional colloid matter in them. There were two further changes, both of which evidenced chronicity in the growth—namely, fibroid induration and calcareous infiltration. This latter change was in the indurated connective tissue, and probably in connection with some necrosis. The goitre was first noticed sixteen years before death. There were several tumours in the skull, only one of which was visible during life, and had been observed for a year and a half; this was in the occipital region, and it formed here a pulsating swelling. This tumour replaced the bone of the skull over an area an inch and three-quarters in diameter, and projected both outwards and inwards, pushing the torcular herophili before it. Another projected chiefly inwards, and was adherent to the dura mater. All the tumours apparently originated in the diploë of the skull. Their structure was identical with that of the goitre, consisting of innumerable small saccules lined with epithelium, and occasionally with colloid contents. Dr. COATS referred to Cohnheim's case, which was of a similar nature; and he also quoted a case of Wölfler's, in which a tumour, removed during life by Billroth from over the eye, was found to have typically the structure of the ordinary goitre. This patient was also affected with goitre.

Mr. R. J. GODLEE had examined Mr. Morris's specimen of pulsating tumours of the left parietal bone associated with other similar tumours of the right clavicle and both femora recorded in the *Pathological Transactions*, vol. xxxi. There was also a goitre in this case, and the tumour of the skull showed thyroid-like tissue.

Mr. G. R. TURNER mentioned a case of goitre associated with secondary growths in the lung reported in the *Pathological Society's Transactions*.

In reply to Sir James Paget, Dr. COATS said that Wölfler had figured many tumours of the thyroid : carcinomata, sarcomata, and the ordinary forms of goitre. In some cases of advanced goitre the formation of colloid was often more pronounced, leading to the formation of large cysts. In reply to Mr. Godlee, he said that he had not detected sarcomatous tissue in cases of ordinary goitre.

### Academy of Medicine in Ireland.

February 18, 1887.

*Œsophagotomy to Remove a Foreign Body.*—At a meeting of the Surgical Section, held on February 18, Mr. BARTON read a paper entitled, "Œsophagotomy for the Removal of Foreign Bodies." He referred to the removal of a foreign body impacted in the pharynx or Œsophagus as a safe and justifiable operation in cases where removal through the mouth was difficult or impossible to effect. He spoke of the reasons which had probably combined to deter surgeons from performing it more frequently, and detailed the case of a child from whom he had removed by pharyngo-Œsophagotomy the steel roller of a sewing machine, which had been embedded in the pharynx, opposite the cornu of the hyoid bone, for three months. The foreign body, which was larger in diameter than a sixpence, could be felt in the neck, and was safely and easily removed. The child made a good recovery, the greatest difficulty encountered being the feeding of the patient, which was troublesome, owing to the tendency of food to come through the wound, which did not heal for some time. This was overcome by feeding through a stomach tube introduced through the wound. Mr. Barton called particular attention to this plan of alimentation, which he considered would prove of much value in the after-treatment of cases of this class.

April 22, 1887.

*Malignant Disease of the Tonsil.*—Mr. HENRY GRAY CROLY read a paper on primary sarcoma of the tonsil, and detailed the history of two cases. 1. A lad, aged seventeen, was admitted into the City of Dublin Hospital on April 22, 1886, suffering from a tumour involving the left tonsil and soft palate; the boy was in excellent health until six weeks before. The disease commenced like ordinary tonsillitis, and so much did the swelling resemble tonsillar abscess that an exploratory incision was made by the medical gentleman who first saw the case; no pus escaped. The patient suffered from dyspnoea and dysphagia. A glandular swelling subsequently formed in the left digastric space. Sir James Paget, who was in Dublin at the time, kindly saw the patient with Mr. Croly, and concurred in his view of the case and in the proposed treatment; namely, preliminary tracheotomy and removal of the growth from within. Tracheotomy was performed on May 4; the patient experienced much relief. The tonsillar and palate swelling and the digastric tumour disappeared almost entirely after the operation, but soon reappeared. Mr. Croly excised the tumour from beneath the angle of the jaw on May 18, and subsequently the tonsillar and palate growth, by means of the benzoline cautery. The tonsil and digastric tumours were round-celled sarcoma. The disease returned very rapidly in the digastric space, and afterwards in the palate. The patient got drowsy, and suffered from violent headaches; the glands in the neck enlarged; he returned to the country and died in October—six months from the commencement of the disease. The second case occurred in a man over fifty years of age. The sarcoma was confined to the tonsil, and so much did it simulate tonsillar abscess that an incision was made into the tumour. Mr. Croly declined to operate, owing to the extensive infiltration of the cervical glands. The patient returned to the country, and died from exhaustion caused by repeated hæmorrhages.

The PRESIDENT said the first case was one of great clinical interest, and of



exceptional rarity. Though the operative measure was not attended with success, yet that procedure was fully justified.

Mr. HAMILTON, having seen the case in conjunction with Sir James Paget, was forcibly struck with it as presenting the characteristics of malignant disease.

Mr. THOMSON asked whether Mr. Croly had succeeded by this method getting away the whole of the tonsil with the cautery.

Mr. W. THORNLEY STOKER said he was fond of the thermo-cautery, and used it freely and frequently; but this was one of the cases in which he would divide the cheek and jaw, and enucleate the gland from its attachment by means of an instrument of less facility.

Mr. KENDAL FRANKS concurred with Mr. Stoker in his objection to the thermo-cautery. Although he had been looking at tonsils a good deal, he had never seen a case of primary cancer. He had, however, operated on cancerous tonsil in connection with disease of the tongue, the details of which he brought before the Academy.

Mr. CORLEY would have considerable hesitation in applying the point of a thermo-cautery to a tonsil, either externally or inside.

Mr. CROLY replied.

### Clinical Society of London.

*April 22nd, 1887.*

*Difficulties in Establishing Natural Respiration after Tracheotomy.*—Mr. BILTON POLLARD referred to three cases illustrating these difficulties, and drew attention to their treatment by tracheal catheterism. He said that the difficulty in getting rid of the tube after tracheotomy was by no means uncommon, and in two of the cases related it persisted after most determined and persevering attempts had been made for more than a year and a half by the usual methods; two of the cases had been for a long time under the care of Mr. Godlee, and had passed into Mr. Pollard's hands when he succeeded Mr. Godlee at the North-Eastern Hospital for Children. The first case was a boy, aged two-and-a-half, on whom tracheotomy had been performed for laryngitis. For eight months frequent attempts were made to dispense with the tube. Mr. Godlee then catheterised the larynx without benefit. Five and a half months later Mr. Godlee passed a piece of india-rubber tubing through the larynx from the mouth to the tracheotomy wound, and left it in position for forty-eight hours without any improvement in laryngeal respiration. The operation was repeated four months later without success. A year and seven months after the tracheotomy, Mr. Pollard passed a tracheal catheter from the mouth, through the glottis, and into the trachea, beyond the tracheotomy opening. It was retained for thirty-one hours, and, after its removal, the patient continued to breathe through his mouth. The tracheotomy wound was firmly healed in a fortnight, and the child had been perfectly well for the six months that had passed since the operation. In the second case (a boy, aged six) the wind-pipe had been opened for laryngitis. Three months after the operation, all attempts to get rid of the tube having failed, Mr. Pollard passed the tracheal catheter, and in doing so dislodged a piece of granulation tissue, which was coughed up. Pneumonia followed in this case, but the patient was nevertheless cured, and was discharged a fortnight after the operation. He had remained perfectly well for the three months that had passed since the operation. In the third case (a boy, aged four), the operation had been performed for impaction of a foreign body in the right bronchus. For seven months attempts were made to get rid of the tube. Mr. Godlee then removed granulation tissue from the trachea, and catheterised the larynx. The latter procedure was frequently repeated during the next three and a half months. Two years and three months after the tracheotomy,



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Mr. Pollard found the vocal cords adherent; he separated them, and, after dilating the glottis with Lister's sounds, passed the tracheal catheter. It was kept in position for thirty-eight hours. It was not until three weeks after this operation that the patient breathed through his mouth alone. The boy's voice returned, but after four weeks, laryngeal respiration was so difficult, owing to the vocal cords having grown together again, that the trachea had to be reopened. The only difference between the plan Mr. Pollard followed and that Mr. Godlee adopted was that, by keeping the tube in the trachea whilst the tracheotomy wound was allowed to close, the patients were left, on its removal, without the opportunity of making use of the passage which, from constant employment, had become for them the natural one. In the first and second cases, the chief cause of obstruction was laryngeal spasm, but in the second there was also a growth of granulation tissue. In the third case, there was a genuine stricture of the larynx, and the tracheal catheter served as a means of continuous dilatation. The result in this case showed that the dilatation should have been employed for a longer period. In two of the cases the tracheotomy incision had divided the cricoid cartilage, and Mr. Pollard suggested that this method of operating might be a cause of the difficulty of re-establishing laryngeal respiration in those cases.

### Leeds and West Riding Medico-Chirurgical Society.

May 6, 1887.

*Adenoid Vegetations in the Naso-pharynx.*—Dr. BRONNER described several cases, and said that he preferred in most instances operating without any anæsthetic but cocaine. He had found Dalby's steel nail very useful.

*Gaseous Enemata.*—Dr. GIBSON showed the original form of Dr. Bergeon's apparatus for the rectal injection of sulphide of hydrogen and disulphide of carbon. He was using the latter on several cases with apparently good results.

*Aneurysm of Thoracic Aorta with Asthmatic Symptoms.*—Dr. CHURTON showed this specimen from a man, aged fifty. Though no physical signs existed, the presence of an aneurysm had been inferred from the fact that attacks of dyspnoea always came on if the patient moved about much even if in bed. The aneurysm, which was small, sprang from the third part of the arch, and was in contact with the bifurcation of the trachea.

### Harveian Society.

May 19, 1887.

*Macroglossia.*—Mr. EUSTACE CALLENDER showed a case of macroglossia occurring in an infant of two months. The tongue was constantly protruded from the mouth, but did not interfere with suckling nor seem to affect the general health. Distinct increase had been noticed since birth.

The PRESIDENT remarked on the morbid anatomy of these cases, and pointed out that the hypertrophy was occasionally due to overgrowth of the lymphatic tissue, or some interference with the lymphatic circulation. In a case of his own under recent observation, the macroglossia had depended on the presence of nœvoid tissue in the substance of the tongue. The prognosis was unfavourable in these cases.

Dr. MAGUIRE stated that some years ago he had published, in the *Journal of Anatomy*, an account of the examination he had made in a case of this disorder. He had found that the enlargement of the tongue was due to dilatation of the lymphatics, and these could be seen in all stages of development, until, in the final stage, a cystic lymphangioma was produced. Another case, which he had since examined, presented a similar appearance, and in both cases the tongue

affection was complicated by the presence of hygroma at each angle of the jaw. He knew of one case which recovered after the use of Paquelin's cautery.

Mr. HERBERT ALLINGHAM, while admitting the possibility of nævoid and lymphatic disease as a cause of the macroglossia, had seen cases where a simple muscular hypertrophy existed, and in which cure had resulted from excision of a wedge-shaped piece of the tongue.

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## NOTES.

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**The Fungus of Thrush** is said by Andry to develop in two forms. When grown in bouillon it flourishes remarkably, turning the fluid turbid, and exhibiting large mycelia—the true *oidium albicans*. An acid medium favours the growth, borax arrests it. When grown on solid media the thrush fungus remains an *oidium* and resembling other fungi.

**At the Banquet** of the American Medical Editors' Association, in Chicago, May 6, the toast to the International Congress, "I'll bring the word straight, how 'tis like to go," was responded to by Dr. N. S. Davis, the president of the congress. He said: "From the best evidences I can get, I feel the congress will be a great success. I have been spending the entire day in meeting the executive committee of the congress, and this is the final general meeting for the committee. We have received reports from committees, from officers of sections with reports of the numbers enlisted, and with reports of papers, some of which are already in the hands of the sections. A great number are from the other side of the Atlantic as well as this, and the prospect is favourable in all respects. If I mistake not, the number directly and indirectly enlisted is not far from one thousand, and about one-half this number are from the other side of the Atlantic. They embrace men as high in their profession as in any part of the world." The speaker then briefly spoke of the opposition in the past toward the organization of the congress, but said that opposition had almost entirely disappeared. In conclusion he extended a hearty invitation to all to go into the congress, and unite in making it an honour to the medical profession of the United States.—*Weekly Med. Review*, June 18, 1887.

**Translation of the Talmud.**—The proposition of Dr. C. H. von Klein, of Dayton, which appeared in all the medical journals some few weeks ago, and which was to the effect that he would translate the medical part of the Talmud provided a thousand subscribers were assured beforehand, has met with great approval, as evidenced by the securing of 500 names already, with good prospects for many more. The medicine of the Talmud antedates that of Hippocrates by 300 years, and its historical interest is readily apparent.—*Weekly Medical Review*.

**Rapid Staining of the Tubercle Bacillus.**—Dr. H. S. Gabbett, in a letter to the *Lancet*, says:—"I can strongly recommend the following mode of staining the tubercle bacillus in cover-glass preparations for clinical purposes. It is a slight modification of Neelsen's method. The stain—which in my opinion is preferable to any of those containing solutions of aniline—is made by dissolving one part of magenta in 100 of a 5 per cent. watery solution of carbolic acid, and adding 10 of absolute alcohol. A sufficiency of this fluid is poured into a watch-glass, and heated on a retort-stand over a spirit lamp till steam rises freely and

the temperature is not very far from the boiling point. The cover-glasses, prepared in the usual way, are then floated in the stain for two minutes ; if the right temperature has been reached this is quite long enough ; the watch-glass should be covered. In Neelsen's method the preparations are then decolourized with acid, and subsequently stained with blue as a contrast. I find that these processes may be very conveniently combined by dissolving methylene blue in 25 per cent. sulphuric acid till a deep colour is obtained, and immersing the cover-glasses for one minute in this immediately after their removal from the magenta. They are then rinsed in water, dried, and mounted in balsam. The whole process of staining and mounting occupies about six minutes according to my experience. Possibly this method may have been already suggested ; if so it has escaped my notice."

**Specialism in France.**—A recent writer in the *Journal de Médecine de Paris* laments the fact that French surgery is dying, notwithstanding that it is still represented by a group of eminent men. It is dying by a process of slow suicide, brought about by routine, blunders, and pride and vanity on the part of the leaders of surgery. The opinion of these masters, descendants of great surgical celebrities, of great pretensions, reaching the summit of science and art, eminent at twenty-one, and great ever after by a sort of *mirage* effect, causes their already senile ideas to prevail with the legislators, magistrates, and administrators. Young men, put down by *concours*, by mode of election, by a reign of terror, are forced humbly to submit, and so the reaction which would be led by them is nipped in the bud. The evil is the hatred and contempt of specialization. The specialist is held to be an inferior and often a charlatan. If he is not dubbed quack he is at least considered ignorant. These great masters accord only to themselves, and those who surround and flatter them, the brevet of honesty and science, and regard every surgeon who is a specialist as fallen or morally degraded. The remedy for this state of things is specialism. Let it only prevail and French surgery will recover all its glory. The day when a man, be he ever so great a genius, will realize that he cannot know everything, and that he becomes superior only so much as he restricts himself, will be a day of light for our surgery. It is thorough specialism that is required, not the timid efforts now made in that direction. The author proposes a plan of education that will necessitate the attention to some specialty, after general education has been obtained, and before the hospital appointment is attained. Unhappily, he sees little likelihood of his remedy being adopted.

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THE PARETIC PALATE.

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DISREGARDING those cases of paralysed velum following diphtheria or due to central nerve disease, we may affirm that enfeebled action of the muscular apparatus of the soft palate has scarcely received the attention it deserves. Both as an objective sign of collateral disease, and as a cause of subjective symptoms for which direct relief is sought, it frequently falls under the observation of the laryngologist.

The affection may be defined as enfeeblement of the levators of the palate, generally accompanied by more or less anæsthesia of its anterior surface, at any rate so far as tactile sensation is concerned. But it cannot be regarded as a disease *per se*, as it is merely symptomatic of some other affection. In fact, it generally exists to a greater or less degree whenever there is acute or chronic inflammatory trouble in the neighbourhood.

In a condition of health, even the gentlest buccal inspiration suffices to raise the velum so as to cut off completely the nasal cavities. In the paretic condition we observe it depending almost perpendicularly from the margin of the hard palate, while tactile stimulation produces either but feeble and momentary contraction, or none whatever. The palatal mucous membrane may be in the so-called hypertrophic or atrophic condition, but generally the former; and correspondingly congested or anæmic.

We will first consider the paretic palate as an objective sign of more important disease. It very frequently accompanies post-nasal catarrh, and hence necessarily the various sources of this complaint. Thus it is seen especially in post-nasal adenoids and in posterior enlargement of the inferior turbinated bodies. In the former it is occasionally intensified by mechanical pressure of the neoplasms; while in the latter we believe it is invariably present in a very marked degree, and in this case also pressure may be an important element in its production. Both in post-nasal adenoids, and enlargement of the inferior turbinated body, the soft palate is always thickened and congested. In the catarrh induced by nasal polypi the enfeeble-



ment is more rarely seen, the velum in these cases being generally the reverse of hypertrophied, and often distinctly anæmic. Again, in acute inflammatory attacks both of the pharynx and nasopharynx, the paresis is always present to a greater or less degree, and accounts for much of the difficulty in speech usually observed. Lastly, as an accompaniment of an elongated uvula the symptom, although less marked, is seldom absent. But of this we shall say more presently.

The subjective symptoms of the paretic palate, for which alone, as we have said, the patient often seeks the specialist's aid, are confined to faults of articulation. Sometimes the sufferer merely complains of a thickness in his speech, which, scientifically interpreted, may be described as a lack of sharpness in the gutturals. Thus *kill* becomes *gill*, *g* being substituted for *k*. More rarely the patient complains that he speaks through his nose, or as though he had a perpetual cold in the head. In fact, he confuses nasal obstruction with inability to close the naso-pharyngeal region. Indeed, the physician must often listen attentively in order to discriminate between the two conditions, especially when they are associated, as is not infrequently the case. In extreme degrees of enfeebled palate, the defective articulation closely resembles that observed in cleft-palate patients. *d* approximates to *n*, and *b* to *m*; *k* and the hard *g* even may be impossible, while *s* is also difficult to accentuate. In such cases the sufferer literally speaks through his nose. Considering the prevalence of post-nasal catarrh in America, we may assume also the frequency of an enfeebled palate, and thus possibly account for the so-called Yankee twang. The thickness in the speech is sometimes discovered only by the singing master, who sends his pupil to the laryngologist with the request that his uvula be cut. Nevertheless, that much-abused member may be perfectly normal in size, although, from the lowered plane assumed by the velum, the symptoms are mechanically identical with those due to elongation of the uvula. The pathology of the affection is probably simple enough, although different in the hypertrophic and atrophic varieties. In the former—which, as we have indicated, occurs in conjunction with catarrhal conditions—we must infer a hyperæmia of the palatine mucous membrane and glands, the latter being particularly numerous on the upper surface of the velum, as part of the general affection. And it is no more than probable that the subjacent muscular structures will be in a similar state of congestion, and hence sluggish in their contractions. And the same state of hypernutrition produces, we



may surmise, the elongation of the uvula and general thickening of the velum.

In the atrophic cases, on the other hand, we find the local affection but an expression of a systemic anæmia; and although the paretic palate in such cases is rarer, it is yet not infrequent, and often more absolute. In such cases the explanation is to be found in enfeeblement of the whole muscular system. The pharyngeal constrictors are often weakened in like manner, and the patient suffers not only from defective articulation, but also from the so-called functional dysphagia.

There is little to be done in treatment beyond remedying the primary cause of the affection. Occasionally a palliative line of treatment may be adopted with great benefit to the articulation. In some cases, for instance, where the pendulous palate appears to act rather as an obstruction to articulation than faulty in its movements, we have seen the greatest benefit accrue from shortening the uvula, and even from trimming the margins of the velum of its redundant mucous membrane. But generally our object beyond treating the catarrh, &c., should be directed towards giving increased tone to the muscular structures involved. Faradism has proved beneficial, while the levators of the palate may be thrown into action by such gymnastics as frequent gargling and singing head- and falsetto-notes.

G. McD.

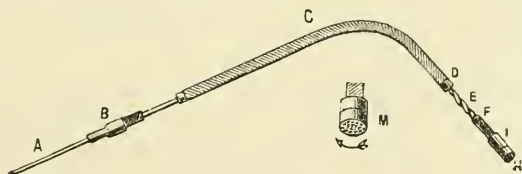
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## INSTRUMENTS AND THERAPEUTICS.

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**GAREL** (Lyons).—Instrument for the Scarification of the Vocal Cords. *Ann. des Mal. de l'Oreille du Larynx, &c.*, June, 1887.

THIS is devised for use in chronic hyperplasia of the vocal cords.



The trunk, A, is soldered to a brass spiral, C; at the extremity of this spiral is fixed a nut, D, fixed to a piece of twisted steel, E. All movements of the nut give to the piece E a movement of rotation on its axis, so as to turn the extremity, H, with its rasping surface. In M is seen the extremity of the instrument.

The piece H cannot become detached.

**HARTMANN** (Berlin).—Instruments for Examination and Treatment of Diseases of the Ear and the Nose. *Monatsch. für Aerztl. Polytechnik*, 1887, No. 6.

1. FORCEPS for the nose to remove excretions and foreign bodies.
2. Curettes for the naso-pharynx for operating upon adenoid vegetations.
3. Tube to introduce into the nose for injections.
4. Speculum for the nose similar to Cramer's ear speculum.
5. Palate hook which can be fixed on the head of the patient.
6. Speculum for the mouth; modification of Whitehead's speculum.

MICHAEL.

**POLLOK, ROBERT** (Pollokshields).—The Treatment of Erysipelas. *Glasgow Med. Jour.*, May, 1887.

The author concludes a short article on this subject by a special reference to the windpipe:—"When erysipelas commences in the throat, inhalation, or the steam atomiser with some antiseptic, should be used. Watch carefully for œdema glottidis. If it does occur, tracheotomy is the only resource." The main body of the article is taken up with the treatment of erysipelas of the skin.

HUNTER MACKENZIE.

**RUMBOLD, T. R.** (St. Louis).—Stop your Coughing. *Maryland Med. Journal*, December 4, 1886.

IF the tendency to cough be resisted, and the sensation seemingly causing it be endured, the number of coughs can be greatly reduced. The sensation which induces the cough frequently arises from irritation behind the soft palate, fully  $3\frac{1}{2}$  inches above the place of sensation in the throat. By marking each cough on a card, and keeping a daily tally, Rumbold has known the efforts to be decreased 75 per cent.

J. N. MACKENZIE.

**RUMBOLD, T. F.** (St. Louis).—The Importance of Hygienic Measures in the Treatment of Nasal Catarrh. *Journal of the Amer. Med. Assoc.*, May 28, 1887.

EVERY physician should bear in mind the proneness of male patients to commit excesses, and that of females to imperfectly and insufficiently clothe themselves. He should secure the co-operation of the patient with reference to an implicit obedience to the laws of health, for in the majority of cases more can be done by hygienic measures alone than by therapeutic measures alone.

J. N. MACKENZIE.

**PERRET**.—Treatment of Tuberculosis by Rectal Injections of Sulphuretted Hydrogen and Eucalyptol. *Soc. de Méd. de Lyon*, May, 1887.

THE results of experiments on eighteen patients are thus recorded:—

1. The rectal injections do not possess any microbicidal action.
2. They modify the bronchitic phenomena and diminish expectoration.
3. They react on nutrition, especially in the apyretic forms, in the same manner as other medicaments. JOAL.

**BOUVERET AND PECHADE.**—Subcutaneous Injections of Eucalyptol in the Treatment of Phthisis. *Lyon Médical*, March, 1887.

BOUVERET has experimented upon twenty-two phthisical patients; six having the pyretic and sixteen the apyretic form of the disease. He finds that the treatment is badly borne by patients who do not undergo it willingly. He finds that eucalyptol is not able to moderate or arrest the development of the tubercle bacillus, and it is not in any sense a specific. The drug exerts no influence on the fever; the disease progresses in spite of large doses and long continuance of the medicament. It exerts no influence on the increase of pathogenic microphytes.

If eucalyptol is without action on the fever which arises in the course of tubercular infection, has it any influence on septic fever? The authors do not believe it. In four patients without fever, amelioration of the accompanying bronchial catarrh was obtained with diminution of the cough; the sputa were modified, and contained less pus. The sweats diminished in the greater number of the apyretic patients, and even in five cases of febrile phthisis.

In conclusion, eucalyptol is in no sense a specific for tuberculosis, but simply a new method of applying the old balsamic medication. The author's report is a very conscientious clinical contribution.

JOAL.

**BIOT.**—Remarks on the Hypodermic Injection of Eucalyptol. *Lyon Médical*, May 22, 1887.

THE author endeavours to combat the conclusions arrived at in the excellent work of Dr. Bouveret, and wishes to reclaim this medication from the discredit with which it is threatened. He insists on its innocence, ease of application and certainty, and defends himself against holding the opinion of its certainty of curing phthisis. Dr. Biot, however, cites too few and too inconclusive results to convince others.

JOAL.

**CHAMPIONNIÈRE, PAUL LUCAS.**—On Some New Treatments of Pulmonary and Laryngeal Tuberculosis. *Journal de Med. et Chirurg. Pratique*, May 1887.

AN excellent article on the new methods of treatment in vogue in France, intra-pulmonary injections with corrosive sublimate, rectal

gaseous injections, and subcutaneous injections. The author thinks that these methods do not satisfy the hopes first raised by their introduction; the intra-pulmonary injections of corrosive sublimate have been abandoned, gaseous rectal injections yield the same results as inhalations of carbonic acid, subcutaneous injections of eucalyptol have no microbicidal action, and this is only a variation of the balsamic method of treatment. JOAL.

**BRUNN** (Leppspringe).—**Therapeutics of Laryngeal Tuberculosis.** *Dtsch. Med. Wochenschr.*, No. 19, 1887.

RECOMMENDATION of lactic acid. For such cases as cannot support this treatment, menthol should be applied. If the disease of the larynx is very advanced, and the lungs are comparatively healthy, tracheotomy should be performed, to prevent the infection of the lungs through the larynx and the inspiration of noxious substances.

MICHAEL.

**BASSOLS Y PRIM.**—**A Case of Tuberculosis treated by Bacteriotherapy.** *Gaceta Médica Catalana*, February, 1887.

A YOUNG man of 23, having nursed his sister, fell ill with pulmonary and laryngeal tuberculosis. Bacilli were found in the sputum. The bacterio-therapeutical treatment was commenced when the pulse registered 144, the temperature  $40\cdot4^{\circ}$ , and respirations 40. At first the temperature fell, but after a few days it rose again, and all the other symptoms advanced. The treatment was stopped on the sixtieth day, and the patient died a week after. The author concludes that bacterio-therapy exercised no influence upon the course of the disease. RAMON DE LA SOTA.

**BRUEN, E. T.**—**Bergeon's Method of Treating Phthisis.** *Med. News*, July 2, 1887.

FORTY-TWO cases so treated have benefited; fifteen cases were negative, but of these there were three cases in which the treatment had decidedly good effect, but the favourable condition fluctuated. The favourable results were, lessened cough and expectoration, and disappearance of the signs of bronchial catarrh, lowered temperature, and suspension of night sweats. Temporary reduction of the pulse-rate fifteen to twenty beats, and lowering of the temperature one-half to one degree during administration of the gas. The author used by preference the artificially prepared sulphur-water, and in some cases after several weeks increased the proportions of the two salts (sulphide sodium, chloride sodium, 5 grains each to a pint and a half of water) even up to 15 or 20 grains; but in all cases in which good effects were not secured by the weaker solutions, Dr. Bruen failed

to get any benefit from the stronger solutions. While at first only a pint to a quart of gas was used daily, this may be ultimately increased to a gallon or a gallon and a half. An hour should be occupied in injecting a gallon of the gas. The longer time taken to administer the gas the better, especially when any pain is caused. In cases of intestinal lesion, or diarrhoea, the gas should only be given in very small quantities. Chronic peritonitis contra-indicates its use. The author has not seen any injurious effects, but noted in some cases subnormal temperature during the injection. Dr. Bruen thinks that suitable climatic environment is an all-important adjunct to the treatment. The treatment is chiefly valuable in those cases of pulmonary disease attended with bronchial catarrh, and should be supplemented by appropriate personal hygiene and judicious alimentation. Full clinical notes of these cases are given.

**SHATTUCK AND JACKSON.**—Six Cases of Phthisis and one of Chronic Bronchitis with Emphysema and Asthma treated by Rectal Gaseous Enemata. *Med. News*, July 2, 1887.

SULPHURETTED hydrogen is not fatal to the bacteria of putrefaction. Cultures of staphylococcus aureus and the bacterium of blue pus are found by Trudeau to be unaffected by Richfield Spring and Eaux Bonnes water. The bacilli of tuberculosis are also unaffected. Niepce, however, found that while tubercular sputum exposed to an atmosphere containing 3 per cent.  $H_2S$  for ten minutes was innocuous to rabbits, "the same sputum first exposed to the gas produced the disease in every animal inoculated with it."

The cases selected by the authors were most of them far advanced.

The conclusions drawn were as follows:—

1. Toxic symptoms may follow the injections of sulphuretted hydrogen gas into the rectum, such as nausea, vomiting, general depression or collapse, diarrhoea, and headache.

2. Strong artificial solutions of  $H_2S$  mixed with  $CO_2$  and injected into the rectum, are apt to cause abdominal discomfort; the risk of this is diminished by warming the solution of the former gas.

3. The method is in no case a specific for phthisis. If useful, it is only as auxiliary to older and generally accepted methods.

4. The only benefit which was seen in these cases that can fairly be attributed to the enemata was diminution in the amount of the expectoration. The authors think also that the amount of  $H_2S$  which can be injected safely into the rectum, varies in different individuals, and in the same individual at different times; that *a priori*, it is incredible that any sufficient quantity of gas should pas



through the lungs to have any therapeutic value ; and that the treatment has had some amount of success chiefly on account of its novelty and by suggestion. Full clinical details are given.

**PEPPER AND CROZER GRIFFITH.**—*The Treatment of Phthisis by Gaseous Enemata.* *Med. News*, July 2, 1887.

THE authors conclude thus : Febrile temperature was sometimes lowered, but never to any great extent. Cough and expectoration were occasionally lessened, but oftener unaffected, and sometimes even increased. Weight was oftener lost or stationary, but a decided gain was frequently made, due perhaps partly to the gas, and no doubt in part to the improved conditions of life. Dyspnœa and night-sweats were rarely benefited. The physical signs were in no case altered ; the general health was but seldom made better, and severe colic was a frequent and annoying symptom. They conclude that the treatment has had very undue value attributed to it ; that it is seldom of any real benefit, but that it may prove serviceable in occasional cases.

The authors' cases were twenty-four, to whom the enemata were administered for from twelve to fifty-six days. Morel's apparatus was used, and the injections given from one to three times daily, and from two to six or more quarts of the mixed gases employed. Other treatment was frequently combined with that of Bergeon.

**COHEN, S. SOLIS** (Phila.).—*Asthma Treated by Bergeon's Method.* *Phila. County Med. Society*, May 11, 1887 ; *Med. News*, May 28, 1887.

READING two reported cases of success by Morel, Cohen determined to try the method in a stout woman of fifty years of age. Almost immediate relief was experienced. Some dyspnœa persisted, but there was no further paroxysm, and the dyspnœa disappeared within thirty-six hours. After six injections, the latter ones being prophylactic rather than therapeutic, the patient professed herself as feeling better than for years, and auscultation revealed only normal breath-sounds.

J. N. MACKENZIE.

**HARKIN** (Belfast).—*The Treatment of Epistaxis by Counter-irritation over the Hepatic Region.* *Lancet*, May 7, 1886.

THE writer refers to Verneuil's recent remarks on this subject (see this Journal, p. 231), and states that he drew attention (*Lancet*, October 30) in 1886 to the significance of this method of treatment, recording a case of vicarious bleeding from the under lip which arose immediately after the deligation of hæmorrhoidal tumours with excessive bleeding, and which was cured by blistering over the

liver. Another case of profuse hæmorrhage from piles was cured by the same method, and three cases of epistaxis in young men were instantly relieved by blistering the hepatic region. The writer now quotes another case of epistaxis cured by painting liquor epispaeticus over the hepatic region, and thinks that Verneuil and he have arrived at the same results independently.

**SEVESTRE.**—Treatment of Ulcero-Membranous Stomatitis.

*Journal de Méd. et Chir. Pratique, June, 1887.*

A LECTURE delivered at the "Hôpital des Enfants Assistés," where the disorder is not frequent—only six cases having been seen during six months. The treatment consists in the application of iodoform four times daily. Amelioration is rapid; by the third day of the treatment the exudation diminishes, the gums lose their fungous aspect, and become more healthy in appearance. Iodoform is preferable to chlorate of potash. Sevestre has made comparative experiments with the two drugs, and holds to the incontestable superiority of iodoform.

JOAL.

**MERMOD.**—On Electrolysis in the Treatment of some Affections of the Skin and Mucous Membranes. *Rev. Méd. de la Suisse Romande, February, 1887.*

1. A case of intense coryza with great ulceration of the septum and turbinated bodies; no benefit from local treatment from silver nitrate, iron perchloride, galvano-cautery, calomel, bismuth, &c. Electrolysis in five sittings cured the patient, causing complete cicatrization.

2. A case of cancerous ulceration extending from the internal angle of the left eye to the lateral face of the nose. The cancerous growth could not be extirpated by ordinary means, but electrolysis sufficed in four sittings to heal the ulcerated surface.

3. A case of naso-pharyngeal catarrh, with constant formation of pseudo-membrane resembling diphtheria, on removing which the mucous membrane is left livid, excoriated, painful, and bleeding easily. Cauterization of the pharyngeal bursa led to amendment of the catarrh, but the membranes continued to form. Electrolysis to the pharyngeal wall in two sittings caused complete cure.

These effects seem to the author due rather to special action on the circulation and the nutrition of the tissues than to simple cauterization. While the positive rheophore is as large as possible, the negative rheophore consists of a metallic point, varying in length for each case. The two rheophores should be placed near together to avoid diffusion through the nervous centres. For the nose, the positive rheophore should be placed on the cheek on the same side as is operated on, and in the case of the pharynx it should be placed

on the nape of the neck. The current of the negative pole should traverse the whole thickness of the mucosa; each contact should last four or five seconds. If applied to an ulceration, the base of it should be transfixed as deeply as possible and parallel to the surface.

The strength of current used should be about six to eight cells of a zinc carbon battery. The only drawback to the treatment is the pain, which is however controlled by cocaine. The complaint of vertigo warns that the current is too strong. The author thinks there is a great future for electrolysis in treatment.

**SCHÄFFER** (Bremen).—**Local Treatment of the Diseases of the Trachea and Bronchi.** *Monats. für Ohrenheilk., &c.*, No. 4, 1887.

WHEN Dr. Reichert related his method of instillation of fluids and insufflation of powders into the trachea, most physicians doubted his conclusions on the ground that such an application must necessarily be followed by spasm of the glottis. But the author has repeated the method of Reichert, and has found that it is possible to make such injections and insufflations directly into the trachea if the patient is advised to take a deep inspiration during the insufflation. If the instrument is pushed through the glottis it is possible to inject the medicament into the right or left bronchus. Affections of the trachea are treated in this manner with good results. (I myself have made the same experiments, and have very often injected Bell's solution during deep inspiration. After some hours the sputum could be found to contain white points of plumbic sulphide. I believe this to be the best method of treatment of laryngeal phthisis and subacute laryngitis and tracheitis.)

MICHAEL.

**FLEMING.**—**Therapeutics of Whooping-Cough.** *Jahrb. für Kinderheilk.*, No. 34, 1887.

THE author recommends vaccination if the patients are not already vaccinated; change of air is effective in later stages. If the trachea is full of mucus an emetic must be given. He also recommends pulvis belladonnæ and insufflations of quinine.

MICHAEL.

## DIPHTHERIA.

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**FRUITNIGHT, J. H.** (New York).—**The Local Treatment of Diphtheria.** *Med. Record*, June 4, 1887.

EIGHT cases treated with hyposulphite of soda, in hourly doses of ʒj. of a solution of ʒj. to ʒij. of water. The membrane lessens from hour to hour. The patients retain the solution in the mouth for several minutes before swallowing. Local as well as constitutional action is thus obtained.

**FOCKE** (Bremen).—**Therapeutics of Diphtheria.** *Centralb. für Klin. Med.*, No. 35, 1886.

THE author gives chlorate of potash every other hour, and hydrochloric acid every hour. He has obtained good results, and believes that this is due to effect of the chlorochloric acid. MICHAEL.

**BUNGEROTH** (Berlin).—**Communication on the Effect of Turpentine in Diphtheria.**

A COMMUNICATION of twenty-nine cases where this medicament was applied. The general result shows that the medicament cannot be regarded as a specific, but it undoubtedly favourably influences the local condition. MICHAEL.

**DALY, W. H.** (Pittsburgh).—**The Simplest and most Efficient Treatment of Diphtheria.** (Read May, 1886, at Eighth Annual Meeting of American Laryngological Association.) *Reprint*.

THE credit of the introduction of the calomel treatment of this disease into modern medicine belongs to W. C. Reiter, of Pittsburgh. Daly enthusiastically champions the method, and insists on the following rules of administration:—(1) Give calomel in its purity; (2) give it in large doses; (3) give it frequently; (4) give it until you have the free and characteristic catharsis; (5) give light nutritious diet; (6) give little or no other medicine. If these simple rules are followed, and common sense allowed to take the place of common prejudice, more cures will be shown than by any other method known to modern medicine. J. N. MACKENZIE.

**MANERO, E.**—**Diphtheria. Remarks upon Treatment, Recurrences, and Paralysis.** *La Fraternidad Médico-farmacéutica*, June, 1887.

ALL methods of treatment which martyrise children should be avoided, and the same methods of internal medication should be

employed as is adopted for infectious diseases in general. He believes that recurrences are rare, and up to a certain degree they offer a prognostic guarantee.

RAMON DE LA SOTA.

**FRUILLET, JOSÉ.**—**Clinical Annotations on Several Cases of Diphtheritic Anginæ cured by Sulphide of Calcium and Resorcine.** *Gaceta Medica Catalana*, April 30, 1887.

THE author records five cases of diphtheria, of which two were mild and three serious. All were cured by sulphide of calcium, hydrobromate of quinine, the local application of citron juice, glycerine and resorcine, and balsamic inhalations, convalescence appearing at the end of twelve days.

RAMON DE LA SOTA.

**The Treatment of Diphtheria by Chinoline.** *Rev. de Chirurgie et de Therapeutique*, April 21, 1887.

PURE chinoline is employed in swabbing, or as an irrigation to the diseased surface.

The former is practised every two hours with the following solution :—

R.	Pure chinoline	...	...	...	10 grammes.
	Distilled water	...	...	...	100 „
	Alcohol	...	...	...	100 „

For irrigation the following is used :—

R.	Pure chinoline	...	...	...	2 grammes.
	Distilled water	...	...	...	1000 „
	Alcohol	...	...	...	100 „

JOAL.

**BARRETT, A. E.**—**Diphtheria Circumscripta, or Sandringham Sore Throat.** *Brit. Med. Journ.*, July 23, 1887.

THE author draws attention to certain cases presenting all the essential characters of diphtheria—rapid and extreme exhaustion, and death by asthenia ; and in cases of recovery, the usual paralysis, chiefly observable in the eyes, tongue, palate, and extremities ; but the local manifestation of the disease, instead of being an exudation, with a tendency to spread over the fauces, is rather a circumscribed and ash-coloured slough on one or both tonsils. This slough remains almost stationary, forming a centre from which the surrounding structures are invaded by a low form of inflammation, with sometimes swelling extending to the angle of the jaw, but no suppuration. In favourable cases the swelling terminates in resolution after the slough has become detached.

GREVILLE MACDONALD.



**PASTEUR, W.** (London).—Paralysis of the Diaphragm after Diphtheria, with Extensive Pulmonary Collapse; Recovery. *Lancet*, May 14, 1887.

THE patient was five years old. [The grounds upon which the diagnosis of diphtheria was made are not stated; no history of diphtheria is given, and the only illness preceding the paralytic symptoms which is noted was chicken-pox in March. *On April 28 the boy was in perfect health*, but shortly after this he began to languish, and became rapidly weaker.]

Then followed a train of paralytic symptoms, first in the muscles of the trunk and extremities, with absence of knee-jerk, then involving the heart. Voice and cough became aphonic, swallowing imperfectly performed, the chest movements much impaired, and the diaphragm paralysed, and the right lung collapsed. The diaphragmatic paralysis was diagnosed from the breathing being superior costal in type, and inspiratory protrusion of the epigastrium being completely lost. Under the influence of hypodermic injections of brandy and ether (5ss. of each at intervals of a few hours), and the administration of nutrient enemata, the child made good recovery. Paralysis of the diaphragm after diphtheria is rare, and the author further thinks that recovery from this condition is very rare indeed. [Though it is probable that the case was one of diphtheria, it is by no means certain, and peripheral neuritis frequently owes origin other than diphtheria. Such complications have been noted even after mumps by Joffroy.]

**SCHRAKAMP** (Stuttgart).—Contribution to the Indication, Method, and After-treatment of Tracheotomy in Croup and Diphtheria. *Jahrb. für Kinderheilk.*, Bd. 3 and 4, 1887.

SO-CALLED prophylactic tracheotomies, before dyspnoea is noticed, are not to be recommended, because the desired effect is by no means certain, and the operation is too dangerous. If cyanosis and dyspnoea are present the operation should be performed, and also if the prognosis is bad by reason of other complications. The preparatory operation, with ligation of the vessels, is the best; only in cases where a rapid operation is necessary it is permissible to transfix the skin and the trachea at once. Narcosis is to be recommended in most cases.

MICHAEL.

## TONSILS, PHARYNX, &c.

**FRÖHLICH** (Rièsa). — **Follicular Tonsillitis and Idiopathic Peritonitis.** *Deutsch. Medicinal Ztg.*, No. 73, 1887.

THE following cases are of great interest, because they prove that follicular tonsillitis, which is usually regarded as a harmless disease, can become an object of great importance.

A military musician, L——, acquired a follicular tonsillitis; he had no fever, but the pulse was small and frequent, and the general health bad. The next day temperature 39·1, pulse 108, meteorism, and complaints of abdominal pains. There was also an enlargement of the spleen, rendering the condition like typhoid. But the next day it was obviously seen that the man suffered from a peritonitis. In spite of energetic treatment with ice, calomel, and camphor and benzoin injections, the condition aggravated, the weakness increased, and the patient died the next day. The post-mortem examination showed a simple peritonitis without perforation, cedema pulmonum and swelling of the tonsils, without, however, the presence of membranes. The affection was considered to be simple peritonitis. During the post-mortem examination, the author cut himself in a finger, and in spite of energetic disinfection he was attacked the next day with violent lymphangitis and lymphadenitis of his arm, high fever, and very bad general condition. He also experienced pain in the pharynx, and examination showed a follicular tonsillitis. The next day the wife of the author also suffered from a follicular tonsillitis, and the same day an assistant who had sewn up the cadaver, and also wounded his finger, acquired a follicular tonsillitis. It was now evident there was a connection between the infection of the fingers and the tonsillitis, and that the tonsillitis was also so infectious that the wife had acquired it. It was nearly certain that the tonsillitis of the author and the assistant was caused by the peritoneal pus from the cadaver, and that both affections were caused by the same micro-organism. The author, his wife, and the assistant were successfully cured. The author refers to some cases in literature of similar affections, but the connection is not so certainly established in any of these as in this case. Bacillary examinations were not made because the musician had been already buried when the chain of events became interesting.

MICHAEL.

**RABITSCH** (Cairo).—**Case of Primary Syphilis of One Tonsil.** *Berlin. Klin. Wochenschr.*, No. 17, 1887.

ULCERS of the right tonsil followed by a hubo submaxillaris and syphilitic skin disease, cured by iodine and mercury. MICHAEL.

**SANDS, H. B. (N.Y.).—Obstinate Hæmorrhage after Tonsillotomy. Recovery after Ligation of the Common Carotid Artery and Transfusion of Salt Solution.** *N. Y. Surgical Society, May 11, 1887; Med. News, Phila., May 28, 1887.*

THE hæmorrhage which followed the operation was insignificant, but some hours later the tonsil began to bleed, and continued all night long, in spite of efforts made to restrain it. Although the patient belonged to a family of bleeders, Sands believes the hæmorrhage due to the division of a large tonsillar artery. For details of the case the above reference should be consulted. J. N. MACKENZIE.

**TEMOIN, M.—Retro-Pharyngeal Abscess. Two Cases of Incision, followed by Phenomena of Asphyxia.** *Revue des Maladies de l'Enfance, April, 1887.*

IN these two cases the opening of the abscess was followed—in the first, immediately, and in the second, after a short time—by an accident which might have been fatal, and may have been the cause of the broncho-pneumonia from which the patients suffered; but the special point of interest was the dyspnœa, amounting to real asphyxia. Temoin quotes instances of other authors where the asphyxia was complete from the moment the abscess was opened, and death resulted. So, to avoid the asphyxia and swallowing of pus, he recommends Duprè's method of first inserting a trochar, and then enlarging the incision with a bistoury. Operating in this manner, one need not fear ill effects from a large incision; and, on the other hand, the enlargement of the primary incision renders the patient less liable to a premature closing of the wound. The author omits to speak of the mechanism by which asphyxia is produced. JOAL.

**ERBEN.—Paralysis of Pharynx and Larynx in Unilateral Bulbar-Paralysis.** *Wiener Med. Blätter, Nos. 1 and 2, 1887.*

(1.) A patient, thirty-eight years old, had hemiparesis of the left side and atrophy of the tongue, paralysis of the musculi arytenoidei, and anæsthesia of the pharynx.

(2.) A patient, thirty-six years old, had double ptosis, paralysis of the left oral fold, paralysis of the left side of the palate, anæsthesia of the pharynx, and dyspnœa. MICHAEL.

**VERNEUIL.—Myeloplastic Tumour of the Palatine Arch and Maxillary Sinus.** *Gaz. des Hôp., April 7, 1887.*

THE surgeon is called upon sometimes to practise detestable, but necessary operations, since in some cases they are crowned with success. The patient in question has had for four years a myeloplastic tumour of the upper jawbone. These tumours,

are generally a phenomenon of youth, are indolent, progress slowly, and rarely ulcerate. Very rarely is there any glandular enlargement. The place of origin generally selected is the upper or lower jawbone. In this case it occupied the maxillary sinus, and compressing the nerves had caused trophic lesions of the eye. There was thus a carotid and a maxillary focus, and Verneuil interfered only with repugnance. He proposed to first remove the glandular mass in the neck, ligaturing the external carotid. The operation on the face would comprise two incisions, from the angle (internal) of the eye to the median line of the upper lip, and another semilunar horizontal incision along the edge of the orbit to the malar bone, thus laying bare the whole maxilla and permitting the opening of the sinus and an estimation of the full extent of the tumour.

JOAL.

**PERRY** (Glasgow).—**Impaction of a Bone in the Œsophagus.**

*Glasgow Med. Jour., April, 1887.*

EXHIBITION of specimen before the Pathological and Clinical Society of Glasgow, November 8, 1886. The bone, which measured about  $1\frac{1}{2}$  inches in length, and  $\frac{1}{2}$  inch in breadth, had been impacted in the œsophagus about the level of the upper end of the sternum. The patient had consulted several surgeons in London, who, after passing probangs, had declared there was no bone in the throat. A few days before death, the above piece of bone was coughed up. On post-mortem examination the œsophagus was found to be the seat of a large ulcerated aperture, and in the apex of the left lung there was an abscess. It was presumed that the bone had pierced the lung, and had thus set up disease.

Dr. Newman, referring to the fact that such a large piece of bone had escaped detection, pointed out the advantages to be derived from the use of a resonator-probang in such cases.

HUNTER MACKENZIE.

**SYMONDS, CHARTERS J.** (London).—**The Treatment of Malignant Stricture of the Œsophagus by Tubage or Permanent Catheterism.** *Brit. Med. Journ., April 23, 1887.*

THE author's cases recorded in this paper comprised: 1. Epithelioma of œsophagus, treated by permanent tubage or catheterism; death from extension to pleura and lung. 2. Epithelioma of upper end of the œsophagus, treated by tubage; permanent dilatation effected; death from exhaustion and prevertebral suppuration. 3. Stricture of œsophagus at the lower end; relief by tubage. The author discusses the question of short and long tubes, the effects of the tube, and the applicability of the method. In reviewing the treatment of this form of stricture the author suggests the following plan:—

1. So long as solids can be swallowed, let the patency be maintained by the passage of bougies, for neither by tubage nor through the opening formed by gastrostomy can solid food be introduced. Well-stewed tripe, rabbit, and pigs' and calves' feet are swallowed readily.

2. When solids can no longer be taken, a short tube should be introduced. This, when considerable dilatation has been effected, may be removed altogether from time to time, and the patient allowed to take solids. This form can be worn till the case terminates, unless pulmonary symptoms supervene, especially cough on swallowing.

3. When the passage of fluids can no longer be borne, then they must be withdrawn altogether from the gullet. This can be accomplished in two ways : (*a*) by the use of Krishaber's long tube ; (*b*) by gastrostomy.

The duration of life after this stage has been reached will in no case be long, and it becomes a question of giving the patient the greatest amount of comfort. The experience of others as well as the author shows that long tubes may be worn till the termination of a case ; and that ulceration will be avoided by using rubber tubes, and passing them by the nose. To this method the author gives adhesion, rather than to gastrostomy. Those who have seen many cases know the difficulty that often arises from escape of the gastric juice, and that not a few have been fed into the peritoneum, while the operation, if done when the patient is in a depressed condition, is very likely to be unsuccessful, either from want of union or exhaustion. Other means are sufficient in the earlier stages.

The most recent advocate for gastrostomy, Dr. Gross, seems to believe that only those cases of malignant disease in which there is no ulceration are suitable for permanent catheterism. To this the author may reply that his most successful case had certainly ulceration when first seen ; and this condition existed in all the others at a time when catheterism was giving complete relief.

Again, while thinking that greater caution must be exercised in dealing with disease at the lower end of the tube, it by no means follows that it is impossible, as Dr. Gross suggests, to enter the stomach. One of the author's cases shows this. He had great difficulty in traversing the stricture in two cases ; but believes, with suitable instruments, and a period of complete rest, with the use of sedatives and rectal enemata, most of the strictures will be overcome ; and once a tube has been passed and retained, there will be no further difficulty.

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## NOSE.

**BANDLER** (Prague).—On Spontaneous Epistaxis. *Prüger Med. Wochenschr.*, No. 21, 1887.

THE author has examined fifty-four patients with epistaxis by means of the Duplay speculum. In thirty-seven positive results were obtained. The affection lasted in cases observed for two days to ten years. There was always a little hyperæmic spot or varicose veins in the anterior portion of the septum; sometimes a little excoriation. These places bleed spontaneously, or on slight wounding, such as the application of the speculum or the probe. They were most effectually treated by the galvano-cautery, or by nitrate of silver. In three cases in which the epistaxis was evidently caused by a morbus cordis, local treatment was followed by improvement or recovery.

MICHAEL.

**POOLE, G. K.**—Plugging the Posterior Nares. *Brit. Med. Jour.*, June 25, 1887.

THE use of an india-rubber catheter in place of Bellocq's canula is advocated.

GREVILLE MACDONALD.

**BRESGEN** (Frankfurt o/M.).—Short Remarks on the Swelling of the Nasal Mucous Membrane in the Prone Position. *Dtsch. Med. Wochenschr.*, No. 17, 1887.

MANY observers, of whom the author is one, believe that only those who have a chronic rhinitis experience closure of the under half of the nose in the prone position. That is not caused, as usually is believed, by flow of blood to the deeper structures from gravity, but by nervous influence.

MICHAEL.

**CARLAS.**—A Case of Rhinitis due to Occupation. *France Médicale*, May 12, 1887.

AMONG the accidents due to special occupations observed among the operatives engaged in manipulating arsenical products, hygienists have not omitted to point out the nasal lesions. It is especially prevalent with those who sift the powder in the dry stage, in the factories for manufacturing coloured paper; and sometimes also it is observed in artificial flower makers. The ulcerative rhinitis provoked by arsenical powder is absolutely identical in its course and evolution with that observed among operatives in chrome. It is the same mechanism, the same process, with this difference, that the corrosion of the mucous membrane and the necrosis of the cartilage advances much more rapidly with the chrome

than with the arsenic workers. In arsenical rhinitis, when there is ulceration, it is always at the anterior extremity of the inferior turbinated bone and the projecting fold formed by the extreme edge of the ala. Then follow observations on a patient employed in a manufactory of arsenical colours who presented lesions more serious than usual—viz., complete destruction of the septum; wide, not very deep, ulcerations of the left turbinated bones; the edges of the vomer eroded at points of superficial necrosis; and at many points in the higher regions the probe encountering bone beneath the ulcerated spots. The author concludes with remarks on the differential diagnosis between the affection under consideration and syphilis and scrofula of the nose. JOAL.

**HUNT, MIDDLEMASS** (Liverpool).—Two Cases Illustrating the Diagnosis and Treatment of Foreign Bodies in the Nose. *Glasgow Med. Jour.*, March, 1887.

THE first case was that of a cherry-stone impacted about the middle of the lower turbinated bone on the right side, and obscured by mucus. It was easily removed by bending the point of an ordinary probe, and passing it behind the obstructing body. The patient, a boy of four years, presented the symptoms of strumous ozæna, which disappeared on the removal of the foreign body.

The second case occurred in a child  $2\frac{1}{2}$  years old, who presented the symptoms of nasal obstruction without fœtor. This was found to depend upon the impaction of one-half of a damson stone. The foreign body was removed by forceps.

The author concludes his short notes by laying down a set of rules for the guidance of the surgeon in such cases. He rightly advocates thorough cleansing of the nares, examination by means of the nasal speculum and mirror, not to douche through the opposite nostril (on account of the risk of fluid entering the middle ear by the drawing back of the current on the obstructed side), and to carefully extract the foreign body either by forceps or by passing behind it a bent probe. The local use of cocaine is recommended.

HUNTER MACKENZIE.

**BERRUECO, JOAQUIN.**—Nature of Nasal Polypi and their Treatment. *Anales de Otolog. y Laringologia*, No. 3, 1887.

THE author complains of the want of accuracy shown in the study of different nasal tumours, and the error of denominating all of them as polypi, whatever their nature may be, as this gives rise not only to error of thought but also of treatment. He maintains, contrary to what is repeated in the books, that the greater portion of nasal polypi

are sessile, so that certain modes of treatment, such as the ligature, are impracticable. Mucous polypi, on reproducing themselves, are transformed into fibrous, and occasionally into telangiectatic tumours. He considers electrolysis useful only in the smallest benign tumours, and has never seen a favourable result from intra-parenchymatous injections. He recommends avulsion, since it is performed with the greatest ease and rapidity, and prolongs the interval before recurrence.

RAMON DE LA SOTA.

**VERDÓS, PEDRO.**—A Case of Nasal Polypus with Perforation of the Maxilla. *Revista de Laringología, Otología, y Rinol.*, May, 1887.

THIS case shows how great and dangerous operations can be replaced by other less hazardous methods. A woman of forty-four, for twelve months had experienced difficulty in breathing through the nose. A mucous and subsequently purulent discharge with pain supervened. This discharge became sanious and fœtid, notwithstanding antiseptic irrigations. At the end of a few months there appeared, under the inferior orbital border, an œdematous swelling, which producing continuous weeping, extended to the inferior eyelid, which in turn ulcerated and gave issue to a moveable fibrous and insensitive tumour. The right nasal cavity was occupied by a fibrous tumour, resistant and resembling the tumour in the orbital fossa. No other treatment was permitted than avulsion. This occupied several sittings and a cure was obtained. Only a scar was left.

RAMON DE LA SOTA.

**JARVIS, W. C.** (New York).—A Novel System of Operating for the Correction of the Deflected Septum, by means of an Electric Motor, Nasal Drills, and an Original Spray-producing Device.

*N. Y. Medical Record*, April 9, 1887.

JARVIS has abandoned the cumbersome, awe-inspiring treadle surgical engine for the electric motor. Of all motors, the "C. and C." is the best for the purpose, a single quantity cell furnishing sufficient electromotive force for any ordinary nasal operation. The battery employed is a modification of Bunsen's cells, a plunge, and a gravity battery. Jarvis insists on the employment of *small* nasal drills, and has invented a number of such contrivances, which, together with the other appliances necessary to the operation and his illustrative cases, are described in full in the original article. Those who are about to use this method will find many valuable hints in the excellent paper of Dr. Jarvis.

J. N. MACKENZIE.

**SCHAUS.**—On Curvature of the Nasal Septum. *Langenbeck's Archiv.*, Bd. 35, Heft. 1, p. 151.

IN most cases of this malformation the author found a difference in

the extent of the cavity of both choanæ. He could accurately gauge this difference by digital examination under narcosis. Sometimes an exostosis of the vomer can be mistaken for curvation of the septum. This malformation is often combined with a crooked formation of the whole skull. The examination of 100 skulls showed that the position of the teeth and the form of the palate is often changed by a curved septum; the palate is often especially smaller and much more curved than in normal cases. This may be caused by synostosis of the sutures of the palate. The same deformation of the palate is often found in combination with adenoid vegetations. The interesting statistical details must be studied in the original.

MICHAEL.

**BETTMAN, B.** (Chicago).—**Ocular Troubles of Nasal Origin.**  
*Journal of the Am. Med. Association, May 7, 1887.*

DETAILED report of six cases, in which epiphora, conjunctivitis, photophobia, and pain above the eyes were due to nasal disease, and dissipated on treatment of the nose. Dr. Bettman prefers the galvano-cautery, making three or four applications in a single sitting. Applications restricted to the anterior end of the inferior turbinated bone frequently failed in procuring relief, and in such cases a swelling of the posterior parts of the inferior turbinated bodies was found. The author refers to the monograph of Hack, to the sensitive area of the reviewer, and to the observations of Sajous, and incorrectly states that the erectile nasal tissue was first discovered and described by Kohlrausch and Voltolini. Finally the necessity for examining the nose in obscure eye cases is insisted on.

J. N. MACKENZIE.

**BROWNE, LENNOX** (London).—**Reflex Association of the Eye and Nose in Disease.** *Brit. Med. Journ., May 28, 1887.*

IN 1885 a lady was suffering from severe and increasing glaucoma, iridectomy having been performed on one eye without benefit. The pain was intense. In 1886 she had double pneumonia, followed by asthma. Nasal polypi being subsequently discovered were completely eradicated. In 1887 there was no recurrence; she had no return of the asthma (she had been residing in Jersey for nearly twelve months); the eyes were free from pain, and the sight had improved. There had been no treatment directed to the eyes, and the patient dated her improvement from the cure of the nasal disease.

**BRESGEN** (Frankfurt a/M.).—**Tuberculosis or Lupus of the Nasal Mucous Membrane of the Nose.** *Deutsch. Med. Wochenschr., No. 30, 1887.*

A LADY, thirty-eight years of age, had a bleeding tumour seated on

the left side of the nasal septum. The tumour was as large as a nut and covered with granulations. It was destroyed with chromic acid and the galvano-cautery. Some patches of lupus on the skin proved it to be lupus. The author believes that the cases published by Schäffer as tuberculous tumours of the mucous membrane of the nose are cases of lupus. (Why?—Rev.) MICHAEL.

**HARTMANN** (Berlin).—**On Croup of the Nasal Mucous Membrane, Rhinitis Fibrinosa.** *Deutsch. Med. Wochenschrift*, No. 29, 1887.

THE author has treated six cases of this affection. The disease begins with fever, and like an acute coryza, on removal of the fluid secretion the croupous exudation can be seen on the mucous membrane. The removal of this membrane is followed by bleeding, and the membranes recur. All patients were cured within fourteen days. MICHAEL.

**WEHMER** (Frankfurt-on-Oder).—**On Nasal Diseases combined with Coryza, with Special Review of their Treatment.** *Deutsch. Medicinal Zeitg.*, 1887, No. 61.

A GOOD review of the subject. MICHAEL.

**THOMAS, J. D.**—**Sarcomatous Tumour Removed from Nasopharynx.** *Australasian Medical Gazette*, April, 1887.

THE patient, a girl fourteen years of age, complained of deafness in left ear, and inability to breathe through the nostrils, the left being specially blocked. By aid of the rhinoscope a growth was seen occupying the post-nasal space, growing from the roof of the nasopharynx. Repeated attempts were made to remove it piecemeal, both by nose and naso-pharynx, but this being tedious and unsatisfactory, she was latterly placed under the influence of ether, and with patient in the "hanging-head" position, the base of the tumour was seized with Woakes' forceps, and after a few vigorous wrenches the entire mass was removed. The weight of the growth, which was attached by a short tough pedicle, was a little over 90 grains. J. W. D.

**ROE, J. O.** (Rochester).—**The Deformity termed "Pug Nose," and its Correction by a Simple Operation.** *The Medical Record*, June 4, 1887.

THIS deformity is due to—(1) excessive development of the alæ and cartilaginous portions of the end of the nose; (2) a lack of sufficient development, or a sunken or flattened condition of the base and bridge of the nose, while the end of the nose may be but normally developed; (3) the combination, to a greater or lesser degree, of these conditions. This latter is the most usual. The normal



development of the end of the nose, while the bridge (which at birth is nearly level with the face) remains in its infantile condition, will give the nose a "snubbed appearance." Heredity and obstructed nasal respiration causing a vacuum in the naso-pharynx and drawing-in of the cartilages are the commonest etiological factors. This obstruction is usually accompanied with overgrowth of the end of the nose and congestion of this part. Snub-nose may also be caused by injuries to the bridge, or necrosis of the nasal bones, especially the vomer. The operation is performed thus: The interior of the end of the nose is cocainized (general anæsthesia is not necessary) and brightly illuminated. If the tissue is to be removed from that part where the mucous membrane is not too firmly adherent, the membrane should be dissected back, to be replaced after the operation. The end of the nose is turned upward and backward and held with a retractor by an assistant, and sufficient superfluous tissue is dissected out to allow the nose to conform to the shape desired. Too much tissue must not be removed, and the skin must not be cut, so as not to leave a scar. No after-treatment is necessary in some cases; in others a splint may be moulded to the shape of the nose. When the deformity is due to malformations of the cartilages of the alæ bulging outwards, with corresponding inside concavity, the cartilages may be cut through, so as to destroy their elasticity, with a small tenotomy knife, and the whole enclosed in a splint made by inserting a silver or hard rubber tube into the nostril, and conforming the saddle to the outside. The author has operated successfully on five cases.

**KILLIAN** (Freiburg-in-Baden).—Remarks on Adenoid Vegetations and their Removal with Hartmann's Curette. *Deutsch. Med. Wochenschr.*, No. 25, 1887.

THE author has very frequently operated with this instrument, and has always been content with the results. MICHAEL.

**BRESGEN** (Frankfurt a/M).—The so-called Pharyngeal Tonsil, its Diseases and Treatment. *Deutsch. Med. Wochenschr.*, No. 5.

**TORNWALDT** (Danzig).—The Question of the Bursa Pharyngea. Answer to Dr. Maximilian Bresgen's essay, "The so-called Pharyngeal Tonsil, its Diseases and Treatment." *Deutsch. Med. Wochenschr.*, No. 23, 1887.

**BRESGEN** (Frankfurt a/M).—Reply to Tornwaldt's Answer. *Deutsch. Med. Wochenschr.*, No. 23, 1887.

**SCHWABACH** (Berlin).—The Question of the Bursa Pharyngea.

*Deutsch. Med. Wochenschr.*, No. 27, 1887.

FOUR polemical papers concerning the bursa pharyngea, but only of personal interest to the authors.

MICHAEL.

## LARYNX.

**PICHEVIN.**—Anæsthesia and Tracheotomy. *Gaz. des Hôp.*, 4 and 11, June, 1887.

THE following are the conclusions arrived at by this writer, in respect of the recent discussion at the Société de Chirurgie (see this Journal, pp. 192 and 231).

1. Chloroformization seems to be the usual practice abroad (*i.e.*, in all countries except France) when it is desired to open the laryngo-tracheal passages.

2. Anæsthesia is not as dangerous as might be thought; it has the advantage of calming laryngeal spasm, and suppressing agitation on the part of the patient.

Anæsthesia is indicated—(1) in the operation of tracheotomy; (2) in cases of foreign bodies in the absence of extraction; (3) when the surgeon fears inability to keep his patient quiet; (4) when the thickness of the soft parts to be cut through is considerable; when the larynx is steadied with difficulty; the prominent regions are not well determined; (5) lastly, and above all, when one has not at disposition a sufficient number of intelligent assistants.

JOAL.

**AUDRY.**—Tracheotomy in a Case of Œdematous Laryngitis of Tubercular Nature. *Société Méd. de Lyon*, March, 1887.

THE subject survived three months, and succumbed to numerous hæmoptyses. Audry exhibited the larynx, which showed deep and extensive lesions. The canula was removed on the tenth day after the operation, and the wound healed without any tracheal contraction.

JOAL.

**SMITH, S., and WALDO.**—Three Cases of Intubation of the Larynx. *Lancet*, June 18, 1887.

THE authors conclude by remarking that in each of the cases they would have been absolutely compelled to perform tracheotomy had not intubation been substituted. Their object is rather to show that intubation of the larynx is in some cases attended with perfectly satisfactory results, but yet has dangers of a somewhat more serious character than some recent writers would lead one to suppose.

GREVILLE MACDONALD.

**SOTA, RAMON DE LA.**—Intubation of the Larynx in Croup.  
*Revista Médica de Sevilla*, No. 8, 1887.

THE author records a case of intubation with immediate good results, and relief of the intense dyspnoea at once. The diphtheritic process having, however, extended to the lower air-passages, the little girl died sixty hours after the performance of the operation. Sota gave a clinical lecture on the case in the Polyclinic of the Medical School of Seville, in which the following conclusions were drawn:—1. Whenever asphyxia threatens, by reason of respiratory impediment in the larynx or trachea, laryngeal intubation and tracheotomy are indicated, and one or other must be performed when the life of the patient is in danger. 2. When the dyspnoea depends on bronchial obstruction, no good result can be expected from intubation or tracheotomy; we also observe its uselessness when the diphtheritic swelling has invaded the lower air-passages after having operated on the patient. 3. Laryngeal intubation and tracheotomy are equally efficacious. 4. Intubation is preferable to tracheotomy because it does not risk the life of the patient, causes no pain, is performed without making any wound, does not require the permanent care of an instructed person, convalescence is more rapid, and no after-effects are left. 5. Although the operation is very easy it requires, as all operations do, a certain degree of dexterity which may be obtained by practice on the cadaver or an artificial apparatus.

RAMON DE LA SOTA.

**NEWMAN, DAVID** (Glasgow).—Splinter of a Rifle Ball Removed from the Left Ventricle of the Larynx. *Glasgow Med. Jour.*, May, 1887.

EXHIBITION of specimen before the Pathological and Clinical Society of Glasgow, November 22, 1886. HUNTER MACKENZIE.

**BOYCE, CHARLES** (Maidstone).—Foreign Body in the Air-Passages. *Lancet*, May 28, 1887.

THE mouthpiece of a pipe, about an inch long, and one-third of an inch diameter, was broken off in the patient's mouth by a fall, and was not seen again. Only on lying down at night the breathing became whistling; there was no cough, impairment of breathing, or pain. A laryngoscopic examination was not made. More than three weeks after the occurrence, during a violent fit of coughing, the piece of pipe was brought up, and violent pain at the sternal end of the right clavicle was experienced. The author thinks that the foreign body had been lodged crosswise in the trachea at its bifurcation, its position being slightly altered on lying down.

**COHN, EUGEN.**—On the Results of Extirpation of the Larynx.  
*Deutsch. Med. Wochenschr.*, No. 29, 1887.

FOUR cases of extirpation for carcinoma operated on by Dr. Hahn.

1. A shoemaker, sixty years old. For six months he had pains in the larynx and hoarseness. He had also a tumour, of which a piece was removed by a laryngologist, who diagnosed carcinoma. Tracheotomy and extirpation of the larynx. Tamponnade of the trachea by the press-sponge canula (invented by the reporter). The next day the press-sponge canula was removed, and a canula covered with iodoform gauze introduced. Third day, death from pneumonia and erysipelas of the face.

2. Patient fifty-one years of age. A tumour covered the larynx. Larynx sensible to pressure. No enlarged glands. Deep tracheotomy. Introduction of the iodoform press-sponge canula. Extirpation of the whole larynx. Artificial larynx. Cure.

3. Patient thirty-seven years old. He had for two years hoarseness, which always improved if a piece of a tumour, which existed in the larynx, was taken away. Now he has hoarseness, stridor, and the laryngoscope shows an ulcerating tumour on the right side of the larynx. Tracheotomy, tampon canula. Exsection of the larynx. Scraping with the sharp spoon. Cauterization with the Paquelin cautery. Iodoform gauze tamponnade. The canula could be removed after some weeks. Cure.

4. A patient of fifty-two years of age with carcinoma. Extirpation. Cure. MICHAEL.

**DUPONT.**—Extirpation of the Larynx. *Rev. Méd. de la Suisse Romande, March, 1887.*

BILLROTH first practised this operation. Up to 1884, sixty-eight operations had already been done (not counting those performed in France). Labbé, in a recent communication, counsels preliminary tracheotomy to be performed some time in advance of the major operation. The author thinks the operation should be performed as soon as the disease is recognized. He also thinks that the use of Trendelenberg's canula would avoid preliminary tracheotomy. The author relates the notes of an operation performed by himself, in which he commenced to dissect out and separate the trachea from the œsophagus, intending, after it had been cut through, to suture it to the edge of the wound at the sternal fourchette. He was forced, however, to introduce a canula to prevent asphyxia. The trachea being cut across and fixed to the wound, very slight hæmorrhage occurred, which was easily controlled, and the larynx was then extirpated rapidly without hæmorrhage, along with the epiglottis and a portion

of the pharyngeal wall, which was involved by the growth. Several indurated glands were removed from the submaxillary region. The wound—from the hyoid bone to the sternal fourchette—should be left open and covered with iodoform gauze, placing a pad of ordinary gauze in the superior part of the pharynx. Nothing should be given to eat for twenty-four hours. A sound was introduced into the pharynx, but had to be removed. It was, however, re-introduced several times daily with facility. The author thinks that Trendelenburg's canula should not be left in for fourteen or fifteen days, as has been proposed, since tamponing the wound will suffice to keep the secretions of the wound from entering the trachea.

Many patients have survived this operation 1, 1½ years, and one for 8 years.

In the author's successful case an artificial larynx was tried, but without success, by reason of the saliva which filled the instrument.

**ARIZA, RAFAEL.**—**Syphilitic Laryngitis.** *Revista de Laringologia Otol. y Rinol.*, May, 1887.

ARIZA believes that laryngeal syphilis has not any constant relation in form with the manifestations seen elsewhere. The most usual form of secondary syphilis observed by him was that of mucous patches, which have not in the larynx their typical appearance, but present a tendency to lineal form and to ulceration. In the larynx, syphilitic erythema is oftener combined with patches than in the pharynx. In many patients, the patches observed on the cords, and on the arytenoids, were whitish round spots of the size of a lentil, and in only one patient were they observed upon the epiglottis, as small and irregular erosions of granular surface, and white and red colour.

As a means of discrimination of these patches from tuberculosis, we look for other patches in the mouth and fauces, and note also that there are not any hypertrophied tissues in the larynx as in tuberculosis. Syphilitic patches further develop on the superior surface of the vocal cords, the tubercular ulcer, on the contrary, being situated on their edges. When patches exceptionally assume this latter position, they are distinguished by more or less remarkable vestiges of the syphilitic erythema which is always associated with them. Syphilitic erythema also occurs sometimes without the complication of patches, and it differs from simple catarrhal laryngitis by its colour, the irregular mode of its distribution, and the freedom of the mucous membrane from mucosities. In secondary syphilitic laryngitis there is a special hoarseness; the voice sounds rough, coarse, resonant, and strong like that of a drunkard, and it is not a voice of small intensity. The author relates several cases in order to show that tertiary laryngeal



syphilis is a very dangerous disease, which may cause death, even while yet in a period of curability, if tracheotomy be not performed at the right time ; that its diagnosis can be made even in the absence of antecedent evidence ; that cure is sometimes obtained completely ; that in other cases the patient gets rid of the syphilis, but is compelled to wear the canula all his life ; and finally, that in spite of tracheotomy, death may occur when necrosis has affected the whole or greater part of the laryngeal skeleton. RAMON DE LA SOTA.

**GRÜNWALD.**—On the Combination of Laryngitis and Tuberculosis in the Larynx. *Münchener Med. Wochenschr.*, Nos. 21 and 22, 1887.

REVIEWING the literature of the subject the author draws the following conclusion : If in a larynx is found, besides distinctly radiated cicatrices, progressive destruction, especially on the anterior portion of the epiglottis, or if there are papillary and larger tumours of the posterior wall which are increasing or recurring, the diagnosis of a combination of syphilis and tuberculosis is certain. He relates three very interesting cases of this combination. In the cases formerly published by Schnitzler, this author speaks of transformation of syphilitic ulcers into tubercular. The cases here related show that ulcers of both kinds can exist together. The diagnosis is confirmed by treatment, since anti-syphilitic treatment will cure the ulcers, but tubercular ulcers are always progressive and uninfluenced by such medicaments. MICHAEL.

**FISCHER** (Meran Gleichenberg).—On some rare Cases of Laryngeal Diseases. *Wien. Med. Woch.*, Nos. 17 and 18, 1887.

1. CIRCUMSCRIBED gumma in the larynx in a syphilitic patient of forty-one years old. Round tumour on the posterior wall, looking like a tuberculous affection. The prompt effect of pot. iod. confirmed the diagnosis of syphilis.

2. Laryngitis syphilitica with ulceration of the epiglottis, stenosis of the larynx, and two gummatous tumours of the larynx, cured by local treatment and pot. iodide.

3. Dermoid cyst of the left vocal cord opened with a laryngeal knife. The tumour was fusiform and as large as a hemp seed.

MICHAEL.

**BARLOW, W. H.** (Manchester).—On Respiratory Convulsions, with Especial Reference to Laryngismus Stridulus and Allied Conditions in Infancy. *Brit. Med. Journ.*, June 18, 1887.

OF the deaths of infants under one year of age in England, 73·3 per cent. are returned as "convulsions." Convulsions are in themselves

rarely the cause of death, and when so this is due largely to spasm interfering with respiration and circulation. Hughlings Jackson has pointed out three levels of motor centres, the first and lowest being the grey cells of the anterior cornua of the spinal cord, medulla, and pons. The nuclei of the ocular muscles in the floor of the aqueduct of Sylvius are the highest of these lower motor centres. This level also includes the centres for respiration and circulation, nutrition, and vaso-motor actions. The second, or middle level, includes Hitzig and Ferrier's motor centres in the cerebral cortex, the sensory region, and Horsley and Schäfer's trunk centres. The third, or highest grade, comprises the brain in front of the motor centres, viz., frontal and prefrontal lobes, and the part behind the middle sensory centres. The first and lowest level represents all parts in co-ordinated groups; the second represents the same parts, but doubly indirectly and in co-ordination of greater complexity; the third, or highest level, represents them trebly indirectly and in still greater complexity of co-ordination. There are three kinds of fits: first, epileptic fits depending on discharging lesions of the highest centres; second, epileptiform, depending on similar lesions of the mid-centres; and third, respiratory convulsions due to discharging lesions of the lowest centres, and first in evolution. Laryngismus stridulus, spasmodic asthma, fits in whooping-cough, &c., are examples of the lowest grade convulsions; convulsions commencing in one hand, and "epileptiform," are examples of the second grade lesions; and those commencing with epigastric or cephalic sensations, of the highest level fits, or epilepsy proper. In a young child the lowest grade centres are the most active; the higher centres, being little developed, have little power to check their discharging lesions. These convulsive fits mostly occur in young children who are rickety, and probably often from venosity of the blood (from deficient aeration due to imperfect action of the chest walls); but still more often they are due to anæmia from whatever cause. Any peripheral irritation acting upon these preponderant low level centres also excites convulsion, *e.g.*, gastric disturbance. There is also predisposing cause in the centres themselves of hyperexcitability. Dr. Barlow refers to the frequency of spasm about the muscles of the face, and of "tetany" with this condition. He considers the disease hereditary. In 114 cases, 70 boys were affected, and only 44 girls. In 98 of these cases rickets was noted, and 11 died.

The author thinks that whooping-cough is closely allied to this condition, and convulsions are often present in the more severe cases. Such convulsions also often usher in or complicate severe diseases

of the respiratory organs. Emotion, crying, fright also induce attacks where there is predisposition. Toxic conditions of the blood, such as lead poisoning, also produce spasmodic affections of the larynx. In laryngismus we have two main factors—rickets and venosity of the blood—and any slight peripheral cause, *e.g.*, flatus, is sufficient to induce an attack. In whooping-cough there is specific irritation of the entrance of the larynx.

Every obstruction to respiration should be overcome, and pure warm air is essential. During a convulsion a starch enema of one to three grains of chloral for a one-year-old child is beneficial. Reflex irritations, swollen gums, ascarides, overloaded stomach, &c., should be treated efficiently. Hygienic conditions should be obtained; milk, raw meat, lime water, and cod-liver oil be administered. The bromides with chloral are well borne by children.

**CHEADLE, W. B.** (London).—**Clinical Lecture on Pathology and Treatment of Laryngismus, Tetany, and Convulsions, with Illustrations of Cases.** *Lancet*, May 14, 1887.

THESE disorders are different expressions of the same constitutional, morbid state especially associated with the first two years of life, with the period of rickets and with the period of dentition, all being distinguished by the occurrence of muscular spasms. They are the positive, comparative, and superlative of the convulsive state in children. A predisposing state exists in a condition of hyper-excitability of the nervous system. Two cases of laryngismus are quoted at length, in which the glottic spasm was excited most violently by crying and laughing, also occurring chiefly on waking (from crying). Both children suffered from rickets, and the second case had tetany (thumbs drawn tightly into the palm, which was arched longitudinally, fingers adducted and overlapping; feet arched and toes flexed; the cramps causing pain).

The family history of this case was instructive. Five living children had been born, all plump and apparently healthy. The first had general convulsions at three months, and died in an attack of laryngismus at six months; the second died at six and a half months from diarrhoea and wasting without laryngismus or convulsions; the third is alive, but when an infant had convulsions while teething; the fourth had "croup" at four months, and died at one year and ten months from general convulsions. The tendency to this condition had, the author thinks, been developed by defective nutrition, from hand-feeding. In the adult tetany is not accompanied by laryngismus, since in the infant there is greater reflex nervous

excitability. Even tossing a healthy infant into the air, or a violent fit of passion will cause glottic spasm.

The carpo-pedal contractions so often noted in laryngismus, and supposed to be a symptom of laryngismus (by Ley, West, Hillier, Meigs, Pepper), is really tetany, and the minor symptom is overshadowed by the major. In adults tetanoid contraction alone is the expression of the same condition. The affection occurs in children in nearly every instance under three years of age—the period of rickets and dentition. In every instance seen by the author, rickets has been present. In all Abercrombie's fourteen cases there was rickets, and in all the latter's and also the author's cases, tetany was combined with laryngismus. Dr. Cheadle thinks the latter is invariably bound with rickets, and convulsions are an expression of the same rachitic condition. Gee found rickets in forty-eight cases out of fifty, and noted general convulsions in nineteen out of fifty cases of laryngismus. Rickets is not mere defective nutrition of bone, but of *all* structures, and arises from deficiency of animal albuminates and fats. Consequently, treatment should be directed to this point, both on the part of the infants and the nursing mothers. So long as the excessive irritability of the motor nervous system is evidenced by carpo-pedal contraction, and attacks of laryngismus remain, so long is the child in danger from spasm of the glottis fatally prolonged, or supervention of general convulsions. The treatment of laryngismus should be a dash of cold water in the face; a hot sponge to the larynx; a finger in the throat to induce vomiting; chloral and bromide in the intervals of attacks; high feeding—milk cream, raw meat, infants' food, entire wheat flour, cod-liver oil, syrup of lactophosphate of lime and iron. Brandy ʒss. to ʒj. in half an ounce to one ounce of food every four or six hours, increases blood-flow to anæmic centres, and is a sedative to children.

**NEWMAN, DAVID.**—A Lecture on Some Points in relation to the Diagnostic Significance and Therapeutic Indications of Laryngeal Symptoms resulting from Pressure of Aneurisms upon the Vagus and Recurrent Laryngeal Nerves. *Brit. Med. Journ.* July 2, 1887.

THE purpose of this paper, as the author states, is to represent the general and important facts, the finer distinctions being left out of account. Four highly instructive cases are related, the author's remarks bearing specially upon four points. The first case is one of unusual interest, described by the author as "Aneurysm of innominate artery and descending aorta. Paroxysmal dyspnoea from unilateral spasm of right vocal cord, followed three months later by bilateral spasm of adductors" (due to peripheral irritation of the



right vagus), "and at a more remote date by bilateral paralysis of adductors," due to structural changes in the nerve centres. He shows (1) that aneurism may exist giving rise to laryngeal symptoms only ; (2) that in the early stage pressure may cause paroxysms of the most urgent dyspnoea ; (3) that at a later stage paralysis occurs, usually limited to one side, characterized by phonative waste of breath and imperfect cough, but without dyspnoea, except when reflex spasm is indicated on the opposite side ; and (4) that in certain cases tracheotomy should be performed actually as a remedial measure. In the course of his remarks he discusses the cause of the attacks of dyspnoea. He quotes the experiments of Rosenthal, Rutherford, Waller, &c., and from them draws the conclusion that pressure upon one recurrent laryngeal nerve is not likely to lead to serious dyspnoea; while, on the other hand, pressure on the vagus frequently leads to serious obstruction, by inducing spasm of the adductor muscles on both sides. He next reviews the diagnosis between glottidean obstruction and that arising from pressure on the air-tubes, and points its importance in relation to tracheotomy. In laryngeal dyspnoea the head is thrown backwards, the larynx descends during inspiration, the stridor is associated with a metallic ring, and the voice and cough are altered or suppressed. When the lumen of the trachea is lessened, on the other hand, the head may be thrown forwards, the larynx remains stationary, the stridor is whizzing or sipping, and the voice is weak but not otherwise altered. In conclusion the author discusses the question of tracheotomy. He remarks that experience has taught him that in a large number of cases of aneurism death from hæmoptysis is preceded by threatening of laryngeal suffocation ; and in many cases he has been convinced that the rupture of the sac has been directly caused by the spasmodic attacks of dyspnoea. He affirms that tracheotomy should be resorted to whenever it is evident that the patient's life may be placed in jeopardy by laryngeal dyspnoea. GREVILLE MACDONALD.

**SCHÄFFER** (Bremen).—**Aneurysma of the Aorta Anonyma.** *Monats. für Ohrenheilk.*, No. 1, 1887.

Two cases in which the diagnosis could only be made by laryngoscopic examination. In the first case the patient, sixty years of age, had paralysis of the left vocal cord. Some days later, the patient had a hæmorrhage ; with the laryngoscope a bleeding point could now be seen in the wall of the trachea. It could be accurately determined that that was the place of the perforation. A month later the patient died of hæmorrhage. In the second case there was also paralysis of the left vocal cord, but no more severe symptoms.

MICHAEL.



**KIDD, PERCY.**—Bilateral Paralysis of the Dilator Muscles of the Glottis, with Subsequent Paresis of the Constrictors. *Lancet*, July 16 and 23, 1887.

THE first half of this paper is a *résumé* of the various theories and experiments so often detailed. The author quotes Morell Mackenzie at length, enunciates Rosenbach's and Semon's views as to special vulnerability on the part of the abductor fibres. He allows that these authors may have arrived at their conclusions independently. Next Krause's views are necessarily advanced, and his experiments detailed at some length. Other authors, *e.g.*, Fraenkel, Seifert, Simanowski, are cited, and the author proceeds to relate his case. The patient presented at first the appearance of bilateral paralysis of the dilators, to which was added subsequently paresis of the constrictors of the glottis. The anatomical relations of the new growth found at the necropsy explain the succession of symptoms. Both vagus nerves were compressed above the origin of the recurrent laryngeal nerves, one of the latter being involved. The author opines that Rosenbach and Semon have proved their point as to the vulnerability of the abductor nerve-fibres; but an explanation, he admits, is still wanting.

GREVILLE MACDONALD.

**GOUGENHEIM, Dr.**—Supplementary Glottides. *Revue Mensuelle de Laryngologie*, March, 1887.

THE author relates a case in reference to what for some time he had believed possible, *viz.*, the existence of a supplementary glottis. Having had, however, the opportunity of examining the patient repeatedly, he has become assured of the existence of a respiratory glottis almost normal, which for some days was hidden by the supposed supplementary glottis. Gougenheim then reports two other cases, published in the *Annales des Maladies de l'Oreille et du Larynx*, by Dr. Cadier (1884), and by Dr. Garel (1887). He concludes from these three observations that it is not proved that the glottis can actually be replaced after its destruction by a new glottis, seeing that complete destruction of the vocal cords had not been established in any of the cases. But it is possible that the relations of the neighbouring parts may, in a pathological condition, acquire a physiological importance by augmenting the tones feebly emitted by the altered glottis. At the same time this effect cannot be produced when the condition of the surfaces destined to this *rôle* are the seat of an inflammatory or rather active process—a fact proved not only by the cases cited but by other very numerous instances where aphonia is induced every time the superior vocal bands are actively congested, although the true vocal cords are normal in their colour and function.

JOAL.

**OPPENHEIM** (Berlin).—**Case of Tabes combined with Gastric and Laryngeal Crises and Spasm of Deglutition (Pharyngeal Crises).**

THE pharyngeal crises are spasms of deglutition occurring twenty-four times a minute whenever the patient made an attempt to swallow. The attack lasted ten minutes. The attack occurred spontaneously or upon pressure on a painful spot on the side of the larynx. This symptom has not been described before. MICHAEL.

**BRESGEN.**—**On Premature Fatigue of the Voice (Mogiphonia of B. Fränkel).** *Deutsch. Med. Wochenschr.*, No. 19, 1887.

THE author has sometimes seen cases of mogiphonia, such as are described by B. Fränkel. These cases were mostly combined with affections of the nose. The best treatment for the vocal condition is to treat the nasal affection. This condition is not to be considered as originating by reflex neurosis, but from mechanical impediment to nasal respiration. Some of the patients recognized that they were fatigued by the fact that occlusion of the nose rendered production of sounds difficult.

MICHAEL.

**JACOBSON, ALEXANDER** (St. Petersburg). — **Structure and Function of the Thyro-Arytænoïd Muscle.** *Archiv für Mikroskop. Anatomie*, tome xxix.

JACOBSON observed a case in which the arytænoïd cartilages remained quite immovable in perfect adduction both during phonation and expiration, and also during the deepest inspiration. The left vocal cord, during inspiration, remained immovable in the median line, but the right one, at the same time, was contracted so that its margin became concave, the glottis consequently becoming plano-convex. The case was distinguished by this form of the glottis produced only during inspiration from cases of paresis of the thyro-arytænoïd muscle, in which the glottis remains plano-convex in all attempts at phonation.

As the distribution of the thyro-arytænoïd muscle is not universally agreed upon, the author examined very carefully the topographical distribution of the isolated fasciculi of the muscle. He found the longitudinal fibres which have been described by all authors, and besides these he observed fasciculi passing in different directions; some starting from the processus vocalis and the external surface of the inferior part of the arytænoïd cartilage turned up in an inward direction, to the free margin of the vocal cord, and ended here in oblique manner in parallel rectilinear fibres, which penetrated the tissue of the vocal cord like the oblique teeth of a comb. In many cases these fasciculi were inserted into the vocal cord immediately in front of the point of the processus vocalis, probably

originating from the crico-arytænoid lateralis muscle. Another portion of these fasciculi, starting from the extreme margin, and from the inner and fore part of the processus vocalis, pass behind and to the outer side, and assist, according to Jacobson, by their contraction, in the abduction of the arytænoid cartilage, so that the opening of the glottis is not accomplished exclusively by the posticus muscle. Jacobson attributes to these muscular fasciculi an important effect upon the changes in the elevation of the sound, and compares it to that which is produced by moving and pressing the finger upon a fiddle-string whilst playing it. These fasciculi would, therefore, probably be only found in the well-developed larynges of singers. H. K.

**POIRIER.**—**Lymphatics of the Larynx.** **Lymphatics of the Subglottic Region.** **Pre-laryngeal Gland.** *Ann. des Mal. de l'Oreille, du Larynx, etc., May, 1887.*

THE lymphatic system of the larynx is remarkable for its development. There are two regions, one supraglottic, in which the lymphatics are extremely rich, the other subglottic, in which they form a network with large meshes.

*The lymphatic network of the subglottic region of the larynx* is an extremely rich interlacement of vessels, the mucous membrane almost disappearing when they are injected. It is continuous with the lymphatic network of the trachea. Above it reaches the free edge of the inferior vocal cord, and is continuous with the network of the ventricular region. It forms vertical vessels at the angle of insertion of the vocal cords and thyroid in front, and on the internal face of the arytenoids behind, passing into the vessels of the ventricular region.

*Lymphatics of the ventricular region.*—This is a rich network, continuous with those of the upper and lower glottic regions.

*Lymphatic trunks.*—These are superior and inferior. The former are sufficiently well known. The trunk vessels which proceed from the subglottic region have escaped the observations of anatomists; three or five in number, they traverse the crico-thyroid membrane and pass to a gland in front of this membrane, the pre-laryngeal gland, or into lateral glands, on the lateral and inferior regions of the larynx between this organ and the carotid.

*The pre-laryngeal gland.*—This is not mentioned in text-books. It exists in about 50 per cent. of bodies examined. Its size varies with age of the subject. It is placed in the middle of the fat and arterial and venous branches which fill the V caused by the crico-thyroid muscles. Sometimes (1 in 6) there are two glands, and when this gland is absent, the laryngeal trunk vessels of the subglottic region having

penetrated the crico-thyroid membrane, pass to the inferior lateral chain of glands mentioned before. The laryngeal mucosa thus possesses a rich lymphatic supply, occupying the superficial layer of the mucosa, developed equally in the vestibular, ventricular, and subglottic regions, and being very thin at the free edges of the vocal cords, especially on the under surface. The large trunks follow the course of the laryngeal arteries. A certain number of sub-hyoid abscesses are probably suppurative adenitis of these laryngeal glands.

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## NECK, &c.

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**FUHR.**—Extirpation of the Thyroid Gland. *Archiv für experimentelle Pathol. u. Pharm.*, No 21.

COMMUNICATION of several experiments made upon dogs which prove that after extirpation of the whole gland death followed in every dog; and further that death is caused by the removal of the thyroid, since other operations, such as cutting the nerves or arteries, do not give rise to the same symptoms. Total extirpation of the thyroid is therefore unphysiological, and is not a justifiable operation on the human subject.

MICHAEL.

**REVERDIN, L.**—Contribution to the Study of Myxœdema Consecutive to Total or Partial Extirpation of the Thyroid. *Rev. Méd. de la Suisse Romande*, May and June, 1887.

IN 1882, the author drew attention to a cretinoid condition consecutive to removal of the thyroid, and then stated that he had ceased to remove the whole gland, in the face of these untoward results, contenting himself with enucleating part or removing one lobe only. In the following year, the author, along with Auguste Reverdin, in a study of twenty-two cases operated on by them, called attention to the resemblance of this condition with the "pachydermic cachexia" of Charcot and Gull, and "myxœdema" of Ord, and they proposed the term "operative myxœdema." Kocher's work (to whom the author had communicated his observations in 1882) appeared in 1883, and this author found only two cases out of a total of eighteen total extirpations had escaped this condition, and both these suffered a recurrence of their goitre. Kocher proposed the term "cachexia strumipriva." These results have been plentifully confirmed by other surgeons in various countries. The author gives a complete literary *résumé* of the question. Kocher reported, in 1885, thirty-four cases operated on, of which twenty-four had developed cachexia strumipriva, and later he stated his opinion that in young subjects not having yet attained full development, total extirpation of the goitre was *always*

followed by a cachexia ending in idiocy. Reverdin has seen myxœdema in five cases out of eleven operated on, the worst case being in a patient of twenty years of age. Juillard saw two cases; one in a young man of seventeen, whose further development was arrested. Baumgärtner had seen five cases out of eleven operations, Pietrzikowski recorded three cases out of eleven operations, Buggi two cases in five operations; Occhini a case developing after destruction of a goitre by electrolysis. These cases, with others reported by Bruno, König, Mickulicz, &c., made a total number of more than forty. Wöfler, in 1884, stated that cachexia strumipriva had never been observed in the Vienna clinic, Bottini had not seen it after fifty-two operations, and Bardeleben has been equally fortunate in twelve cases. Trombetta, collecting all statistics possible, puts the percentage of cases after operations at 27 per cent. The author relates three cases in detail, which show that the malady may progress more or less rapidly, and that the symptoms may in certain cases undergo amendment even for many years. He relates two other cases of abortive, or undeveloped myxœdema, in both of which he discovered a slowly appearing ovular and regular small tumour in contact with the thyroid cartilage, and having all the characters of a small accessory thyroid. This gland appears to develop in the same manner as small accessory kidneys do in the dog or young fox after removal of the kidney.

The author also states that partial extirpation may sometimes be followed by myxœdema, and relates a case in which the disorder was in the undeveloped form. He also states that extirpation of one lobe may be followed by atrophy of the rest of the organ with signs of abortive myxœdema. The author is not disposed to condemn irrevocably total extirpation, seeing that sometimes it is necessary, and the operative accidents reveal themselves in an attenuated form. He also relates a communication made to him by Poncet, of Lyons, of a case in which undeveloped myxœdema has occurred in a young girl in whom the thyroid isthmus only was removed. The paper is a very valuable and interesting contribution to the subject.

**DE SOYRE.—Goître dependent on Pregnancy and Accouchement.**

*Archives de Tocologie*, 1887.

WOMEN, independently of any hereditary cause, may present hypertrophy of the thyroid gland at the menstrual periods or during pregnancy. Oftenest after accouchement this hypertrophy remains stationary or diminishes; it may reappear and increase in a subsequent pregnancy. This hypertrophy does not often give rise to any serious consequences, but may compress the trachea, and the consequent symptoms may progressively increase until death occurs.



The surgical intervention called for consists in the simple injection of pure tincture of iodine in those cases which develop slowly. When, however, asphyxia is imminent, it is necessary to practise partial ablation of the thyroid gland. JOAL.

**SNOW, H.** (London).—**Arsenic in Cystic Goître.** *Brit. Med. Journ.*, May 28, 1887.

THE writer thinks that arsenic has a specific effect upon the thyroid gland, and relates a case of cystic bronchocele, which, after tapping, was still of considerable size, but which completely disappeared under the administration of 5-minim doses of liquor arsenici hydrochloricus three times daily.

**VERNEUIL.**—**Adenoma of the Subhyoid Region.** *Gaz. des Hôp.*, April 7, 1887.

A LECTURE given at the "Hôpital de la Pitié," the subject being a man of forty, strong, but possessing a glandular swelling. These tumours are rare. Prof. Verneuil has never seen more than two in the same year. They are innocent both as to nature and operation, and they never recur. The surgeon can seldom be quite certain of his diagnosis. JOAL.

**ZENNER** (Cincinnati).—**Case of Auctioneer's Spasm.** *Berlin. Klin. Wochenschr.*, No. 17, 1887.

AN auctioneer acquired a spasm of the left side of the mouth, which always appeared when he began to cry loud, so that he could not any longer carry on his business. The attack also came on if he spoke quickly, and was combined with pain in the parts affected. He could overcome the spasm if he elevated the oral fold with a pencil during speaking. The treatment was unsuccessful. The author regards the disease as a functional neurosis. MICHAEL.

**FUX.**—**Cocaine Anæsthesia in a Tongue Operation.** *Wiener Med. Wochenschr.*, No. 17, 1887.

THE author extirpated a tumour of the tongue under injections of 10 cgrm. of 5 per cent. solution of cocaine, and the operation was completely analgesic. MICHAEL.

**ANDERSON, WILLIAM** (Newfoundland).—**Cancer of the Lip.** *Glasgow Med. Jour.*, March, 1887.

CONTAINS nothing new.

HUNTER MACKENZIE.

**FRAENKEL, BERNHARD.**—**Introductory Speech at the Opening of the Royal University Polyclinic for Diseases of the Throat and Nose.** *Egypt. Deutsch. Med. Woch.*, No. 23, 1887.

THE author gave a résumé of the history of laryngoscopy and laryngeal surgery, accentuating the connection between this specialty and the other branches of medical science. MICHAEL.

## REPORTS OF SOCIETIES.

### Edinburgh Medico-Chirurgical Society.

*Wednesday, June 15, 1887.*

*Removal of Thyroid Gland in Exophthalmic Goitre.*—Professor T. R. FRASER showed a female patient from whom Sir Joseph Lister had removed, ten years before, the greater part of the thyroid gland, on account of exophthalmic goitre. No trace of exophthalmos could now be distinguished. Further, in view of recent experimental work, it was noteworthy that no symptom suggestive of myxœdema had developed. The patient's cerebral functions were well performed. At present she was unhappily suffering from phthisis. Of peculiar interest was the rapid fall in the pulse-rate which succeeded the operation, from an average of considerably over 100 to normal.

*Wednesday, July 6, 1887.*

*On the Lymphoid Tissue of the Tongue as a Cause of Throat Symptoms.*—After discussing the literature of the subject, Dr. M'BRIDE drew attention to the importance of the lymphoid tissue at the root of the tongue as a factor in the causation of disease. There was no doubt that this tissue underwent considerable hypertrophy in certain subjects. Sometimes the symptoms were not very apparent. In other cases, sensations of burning or pricking were experienced. Sometimes the hypertrophy was so considerable that the free movements of the epiglottis were interfered with. M'Bride had met cases in which the free edge of the epiglottis had become entangled in the folds of hypertrophied mucous membrane.

### Royal Medical and Chirurgical Society.

*June 14, 1887.*

*On a Form of Inflammation of the Lips and Mouth, which sometimes ends fatally, and is usually attended by some Disease of the Skin.* By JONATHAN HUTCHINSON.—The paper contained the description of a disease (not, it is believed, previously recognized) in which superficial ulcerations occur in the lips and in various parts of the mouth, followed sooner or later by some form of skin disease, and tending to a fatal termination. The form of skin disease might vary, but the hands and feet were the parts usually affected, and the nails were especially prone to suffer. In some instances the eruption might consist of bullæ, which were followed by free papillary outgrowths. The patients attacked were usually in middle life, or in early senile periods. No special antecedents could be alleged as the probable cause of the malady. Unless checked by treatment, the disease appeared to run its course in about six months, producing death by exhaustion. There seemed reason to believe that opium given in repeated doses will cure it, and that there was, at any rate in some cases, no tendency to relapse afterwards. All the best marked cases as yet observed had occurred in males, but in several milder ones the patients were women. Of the most characteristic, two were master tanners, one a farmer, one a clergyman, and one a gentleman of no occupation; all these resided in the country. Careful inquiry had failed to support the suspicion that the disease might perhaps be due to contagion from animals. Of these five cases two ended fatally and three in recovery. The patients who died were those first observed, and since the discovery of the signal efficacy of opium, no case had ended in death. The observation as to the efficacy of opium was simultaneously made by the President of the Society, Mr. Pollock, and by the author, two different patients being at the same time under their separate

treatment, and recovering under this drug. Since that, every case had yielded if the dose of opium were sufficiently pushed. In one, however, the disease did not yield quickly, and for more than a month seemed likely to end in death. As regards permanency of cure, in one case the patient was known to be quite well four years after his recovery, in another there was reason to believe that such was the fact, and in the third a period of two years had elapsed. In two of the milder cases, occurring in younger patients, the disease had repeatedly recurred. A great variety of remedies had been tried without benefit before the use of opium was resorted to. In no single case had there appeared to be any tendency to spontaneous improvement. In all cases the inflammation of the lips and mouth took definite precedence of the skin-symptoms, and in some the latter were very slight. It was not known that any case had as yet been obtained amongst the poorer classes of society. The author desired to abstain for the present from expressing any detailed opinion as to the causes or nature of the malady. He would, however, venture to suggest that it was allied to other forms of disturbed health attended by skin disease and occurring in early senile periods, such as certain peculiar varieties of psoriasis, pemphigus, lichen planus, and pityriasis rubra. In confirmation of this suggestion, and as an appendix to the paper, a case was narrated (with a portrait in illustration) in which an elderly lady had a kind of spreading eczema-psoriasis of the hands and scalp. She lost her nails and all her hair, and was rapidly failing in health in spite of various measures of treatment, but finally recovered quickly and completely under opium. Her case did not belong to the group described in the paper, because she never at any time had inflammation of the mouth.

Dr. POLLOCK said opium had been a favourite remedy of his in phagedenæ. During an epidemic of this at St. George's Hospital, he had used it largely and with most satisfactory results. Since then he had had a long experience of its value in curing the inflammatory conditions in the mouths of young children. He had never, thanks to opium, felt the need of any escharotic.

Mr. C. MACNAMARA begged to bear testimony to the valuable debt he owed to Mr. Hutchinson's most careful researches. He had seen a strong man in middle life, with no suspicion of syphilis, or any other serious ill-health, who had been in India, and almost immediately on his return to England, got severe stomatitis, and fell into a state of great prostration. He had heard Mr. Hutchinson speak of similar cases, and put his friend under his care. Unfortunately, he was too far gone to be able to take or persist in taking the necessary opium, and the case ended fatally from emaciation.

Dr. CROCKER had had a similar case under his care, which bore some resemblance to what Neumann had called pemphigus vegetans. He had not been able to do the patient any substantial good. She came subsequently under Mr. Hutchinson, who cured her with the opium treatment.

### **Congress for Internal Medicine, Berlin.**

*Meeting, June 6, 1887.*

A. FRÄNKEL gave facts relating to two patients, the first of whom, thirty-seven years old, had cyanosis and pulsus paradoxus. Then followed a double pleuritic exudation. Puncture with a probe revealed the presence of a great many bacilli and streptococci. Death after two days. The post-mortem examination showed pus in the pericardium and both pleuræ, diphtheria faucium and retropharyngeal abscess.

The second patient was in a stupor when he came under treatment. He had a tumour of the spleen, and petechiæ on the extremities. The post-mortem examination showed endocarditis ulcerosa, diphtheria faucium, broncho-pneumonia, nephritis, infarct of the spleen. In the tonsils, heart, and lungs a great many cocci were

found. It is believed that in both cases a bacillary infection of the throat was the cause of the disease.

FÜRBRINGER agreed with the speaker, and related some similar cases.

GUTTMANN believed that there was no diphtheria in the two cases, but some other infective disease of the throat.

LEYDEN related a case with symptoms similar to the cases of Dr. Fränkel. But some days after the beginning of the treatment, a fluctuation was felt in the pharynx. An incision was made by Dr. Boeker. A great deal of pus came out, and the patient was very much relieved, and cured in some days.

APOLANT related a similar case in his practice.

FRÄNKEI replied to Dr. Guttman that the question if the affection were or were not a true diphtheria could not be decided with certainty. MICHAEL.

### **Berlin Medical Society.**

*April 6, 1887.*

*Treatment of Tuberculosis of the Larynx and Lungs.* By A. ROSENBERG. A recommendation of inhalations of menthol. He has for eighteen months constantly used this method of medication with never varying successful results.

S. ROSENBERG had not seen good results in patients in whom hectic symptoms were pronounced.

FÜRBRINGER believed that menthol yielded good results in phthisis of the larynx, but was not satisfied of its benefit in pulmonary phthisis.

*June 13, 1887.*

*Concretions in Wharton's Duct.* STRASSMAN exhibited fusiform concretions  $2\frac{1}{2}$  centimetres long which he had found in Wharton's duct. The patient was fifty years old, and had twice before been operated on for salivary calculus. The diagnosis is not difficult since the concretion can be felt and cut down upon.

DAVIDSOHN also exhibited a concretion from a salivary gland which he had found in a ranula.

### **Hamburg Society of Physicians.**

*April 4, 1887.*

*Myxædema.* E. FRAENKEL referred to recent writings on this subject, and showed a case of congenital defect of the right lobe of the thyroid gland, and also two specimens of tuberculosis of the thyroid gland.

*July 12, 1887.*

*Stenosis of the Larynx.* THOST demonstrated two patients with this condition. The first had, one and a half years before, typhus fever, for which he had had tracheotomy performed. The treatment consisted in dilatation by bougies, but he was not yet cured.

The second patient had also had typhus and subsequent tracheotomy, and was treated with Stoerk's dilating canula and also with tin bougies. The trachea canula could be removed, and the patient could himself apply Schroetter's hard gum bougies.

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### **Letter from Dr. D. N. RANKIN, of Allegheny, Pa., U.S.A.**

ALLEGHENY, PA., *July 5th, 1887.*

DEAR SIRs,—In your obituary notice of the late Professor Hack, in the June number of your journal, you have erroneously accredited to him some honours which as a matter of correct medical history belong to Dr. W. H. Daly, of Pittsburgh, Pa., U.S.A. I believe the



fact is generally known to laryngologists and the profession everywhere, that to Dr. Daly belongs the honour of making the original observations in 1878, 1879, and 1880, which demonstrated the intranasal causes of hay fever, and he gave the results to the profession in a paper entitled "*Hay Asthma and Naso-Pharyngeal Catarrh*," which he read before the Congress of the *American Laryngological Association* in New York, May, 1881. The paper was published in the *Archives of Laryngology* (vol. iii., No. 2, April, 1882). In that essay Dr. Daly asked the pertinent question—"Whether we are warranted in believing any case of hay asthma purely a neurosis, without first eliminating the possible causation due to local structural or functional disease in the naso-pharynx?" Professor Hack's essay did not appear until 1884, three years after the reading of that paper, and after it had been quoted in medical journals, and reprints sent to laryngologists wherever known, Professor Hack among the number. I herewith transmit you also a copy of the reprint from the press of the *Archives of Laryngology*. This paper contains the gist and kernel of all that has been so ably observed and elaborated upon by Dr. Roe, of Rochester; the lamented Professor Hack; Dr. Mackenzie, of Baltimore; Professor Sajous, of Philadelphia; Professor Bosworth, of New York, and the increasing number of others who have been attracted to this field of observation, and who have so largely verified the original observations made by Dr. Daly. It may be said, with no little honour for him, that by the carrying out of injunctions so forcibly laid down by Dr. Daly in his original essay, Professor Hack and the many others have been enabled to do useful work in advancing this branch of medical science in a sure and lasting manner, and the comprehensive suggestions of Daly have been the means of not only curing more cases of asthma than was accomplished by any other method before known, but also of making a marked advance in the cure of other diseases of the upper air tract.

Yours respectfully,

D. N. RANKIN.

\* \* \* We have much pleasure in publishing the above letter, and we are anxious to do full justice to Dr. Daly, as well as to all those who add to the sum of human knowledge. Perhaps the statement in our June issue that "to Hack undoubtedly belongs the great credit of *first* drawing attention to the subject" of nasal neuroses, is not strictly accurate, though to this author is undoubtedly due the credit of attracting serious attention by his writings to this subject. The credit usually attributed to Voltolini (see *Die Anwendung d. Galvanokaustik*, Wien, 1872), in which he called attention to the



subject six years before Mr. Daly published his interesting paper, should really be given, as is shown by Dr. J. N. Mackenzie's admirable literary researches (see especially *New York Medical Journal*, Feb. 26, 1887), to Rudolf Ferber, of Hamburg, who, in 1869, published a paper entitled *Der Neisekrampf und deren Beziehung zur Migraine, zum Bronchial-asthma, und zum Heufieber*. Hanisch, Schadewald, and Porter also preceded Daly. It is doubtful whether the credit should not even be attributed to Zecchius, who wrote so early as 1650 of the association of nasal catarrh with asthma. Dr. Daly's observations, interesting and important as they undoubtedly were, formed thus one link of an important chain of clinical observations, which has been gradually forging into a consistent whole since Zecchius' time. Dr. Daly may justly be regarded as a founder of that surgical school of rhinology in America, which has at the present day so many distinguished representatives, by drawing forcible attention to the importance of intra-nasal surgical treatment. Hack, and those who partially or entirely share his views of the neurotic origin of these disorders, are disciples of quite a different school of pathological thought, in which the cerebro-spinal and sympathetic nervous systems play the chief part, essentially differing from the surgical school of treatment and pathology, so ably represented by Dr. Daly and others.

EDITORS.

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## NOTES.

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**Polyclinic for Diseases of the Throat and Nose, Berlin.**—The University of Berlin has signalled its respect for the increasing importance of laryngology and rhinology, by opening a special department for instruction in these branches of medical education. This was done June 6, and the well-known Berlin laryngologist, Dr. Bernhard Fraenkel, was appointed the first director and physician to the department. Dr. Fraenkel took occasion, in his opening address, to review the history of laryngology, and to speak at length of its connection with other branches of medical knowledge.

**A Simple Method of Procuring Deglutition where such is impeded by reason of Extensive Ulceration of the Epiglottis.**—Dr. Norris Wolfenden, in a note in the *Lancet*, (July 2, 1887), writes :—"One of the most distressing symptoms accompanying laryngeal phthisis with ulceration of the epiglottis is the difficulty patients experience in swallowing. Especially is this the case in advanced conditions where the epiglottis is more or less completely destroyed. In such circumstances the swallowing of even a teaspoonful of water, or liquid of any kind, is all but impossible, from the violent cough that is excited in consequence of the passage of some of the fluid into the larynx and trachea. Such patients are generally tormented with a thirst which they cannot satisfy, and the painful efforts they make to get down a few drops of liquid, and the terrible spasms of coughing and pain thereby produced, are truly pitiable to observe. One of my patients in the last stage of laryngeal phthisis, and in whom the epiglottis

had more than half disappeared from ulceration, lately taught me a "wrinkle" which others may find of service. He informed me that he had discovered a method of drinking even large quantities of fluid with ease. I asked him to give me a demonstration of the feat, and lying stomach downwards upon the couch in my consulting-room, with the head and arms hanging free over the end, and with the feet higher than the rest of the body, he took a large tumblerful of water in both hands, and placing the open end of a piece of indiarubber tubing (about six inches in length and with a vulcanite mouthpiece) in the fluid, and the mouthpiece between the lips, drained off the contents without stopping, and with the greatest ease and comfort. Not the slightest pain or cough accompanied the act, showing that none of the fluid entered the larynx. The feat was the more remarkable to me, who had often seen him making great efforts to swallow fluids, but unsuccessfully, in the sitting position. In the ordinary position a teaspoonful of fluid was as much as he could manage to get down, and this was accomplished only at the cost of much pain and terrible paroxysms of coughing. The plan is simple enough, and is one which will procure relief for other patients afflicted with the same terrible laryngeal conditions; as I have never seen it applied before, I venture to mention it to those who have to treat similar conditions, and I am sure they will find it an excellent method of alleviating one of the most distressing sufferings of patients of this class."

**Novel Remedy for Asthma.**—Under this title a curious case is related in the *New York Medical Record* of July 9, of a man who for years had been a sufferer from paroxysms of asthma. Acting on the advice of a fellow-workman he proceeded to swallow No. 8 birdshot, taking a teaspoonful three times a day. He appears to have swallowed about two pounds of this novel medicament, and eventually came under treatment, with all the signs of lead poisoning. Purgatives and iodide of potash removed the shot and the plumbism. No attack of asthma occurred while the unlucky patient was loaded with shot (three weeks), though when the charge was withdrawn the disease reasserted itself. This nineteenth century is not much behind its predecessors for credulity!

**New Laryngological Clinic in France.**—The Minister of the Interior has created a laryngological clinic at the "Institution Nationale des Sourds-Muets de Paris," and Dr. Ruault has been appointed to its charge. It will open on October 1.

To ensure the early insertion of abstracts, Authors are requested to send a copy of any journal which may contain a contribution on disease of the throat or nose, or on cognate affections, to the EDITORS, *Journal of Laryngology*, 11, New Burlington Street, London.

Afin de s'assurer une prompte insertion de leurs extraits, les auteurs sont priés d'envoyer un numéro de tout journal contenant un article quelconque sur les maladies de la gorge ou du nez et sur les affections qui y ont rapport, aux REDACTEURS du *Journal of Laryngology*, 11, New Burlington Street, London.

Um die rechtzeitige Veröffentlichung von Auszügen zu sichern, werden die Verfasser gebeten, eine Kopie von allen Zeitschriften, die einen Beitrag über Krankheiten des Kehlkopfes, der Nase u. s. w. enthalten, an die HERAUSGEBER des *Journal of Laryngology*, 11, New Burlington Street, London, zu senden.

*Letters relating to the Editorial business of the Journal are to be addressed "To the Editors."*

*Business communications to be sent to the Publishers, Messrs. J. & A. Churchill, 11, New Burlington Street, London, W.*

THE  
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AND RHINOLOGY.

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SEPTEMBER, 1887.

No. 9.

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A NEW METHOD OF INHALING  
NITRATE OF SILVER IN DIFFERENT  
DISEASES OF THE AIR PASSAGES.

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THE application of nitrate of silver as a remedial agent in catarrhal diseases of the air passages is not only comparatively old (*Ch. Bell*, 1816), but has also proved in the hands of many specialists to be very effective. Hitherto it has been almost entirely administered in the nose, the pharynx, and the larynx, where it is possible to limit its astringent or caustic effect by direct application; attempts, however, have also been made to employ the remedy in diseases of the lower air passages, either by means of spray inhalations (*Ingals, Joseph*) or by injecting a watery solution of it through a catheter passed through the rima glottidis (*Horace Green*). It seems, however, that the application of nitrate of silver in diseases of these parts of the respiratory organs has not been widely adopted, either owing to the circumstance that it is here less therapeutically effective, or—what is more probable—that the modes of application have been imperfect.

Perhaps it will not be out of place to state at once that the method of administering nitrate of silver, which we are about to introduce to the notice of the readers of this Journal, is not based upon a fresh augmentation of the large number of apparatus for inhalation already in existence, but on a new principle and on some properties of the nitrate of silver hitherto unknown, or at least undescribed, both accidentally discovered in 1874 by a Norwegian photographer.<sup>1</sup> He was standing boiling a solution of silver in nitric acid, when he happened to inhale for some time the vapours which arose; now he had for a long time suffered from a very severe and obstinate chronic bronchitis, but after the first irritation of the acid vapours had passed off, he felt a pleasant warm sensation in the chest, and from that

<sup>1</sup> *Forhandlinger i det Norske Medicinske Selskab* i 1874, p. 226; *Bilag til Norsk Magazin for Lægevidenskaben*, 1874.

moment the cough left him. He also found that by placing pieces of white paper in different parts of the room, where he boiled the solution, and afterwards exposing them to the light, they became covered with very fine black spots, a proof that nitrate of silver was suspended in the air in very fine particles. The photographer imparted his discovery to Dr. Bidentkap, a distinguished physician of Christiania, who took the matter under investigation and tried the inhalations on a great number of patients with different diseases of the air passages, only altering the original experiment so that less acid vapours were developed.

Before describing the results of Dr. Bidentkap's investigations, we will examine the chemical and mechanical processes that are produced by dissolving silver in boiling nitric acid. First the silver is transformed into nitrate of silver, which partially dissolves in the water; secondly, the nitric acid is decomposed into different gases, such as nitric oxide ( $\text{NO}$ ), nitrous acid ( $\text{N}_2\text{O}_3$ ), and nitric peroxide ( $\text{NO}_2$ ), which latter two gases can be detected by their smell and colour. Thirdly, the nitrate of silver is dissipated, as proved by the fine black spots found on the white paper placed in different parts of the room, and afterwards exposed to the light. The way in which the nitrate of silver is dissipated is probably by a mechanical process, the different gases carrying with them the salt in particles so fine and light that they can even reach the under surface of the white paper, when this is placed so that the edges are free. Besides this, the evaporation of the watery solution undoubtedly carries the nitrate of silver off into the surrounding air as shown by some larger spots on the white paper.

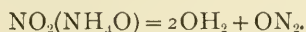
Dr. Bidentkap<sup>1</sup> tried the inhalations on 120 patients, by letting them remain one to two hours every two to four days in the room where the vapours were produced. His results were, on the whole, exceedingly favourable and in some cases even surprising, and he strongly advocated the inhalations, especially in cases of chronic catarrh of the nose and the pharynx, in chronic laryngitis and tracheitis, without complications, such as ulcers, polypi, &c., and in chronic bronchitis, even associated with emphysema. Cases with abundant expectoration seemed to yield most to the treatment.

The results of Dr. Bidentkap's investigations were not corroborated until eleven years later by Dr. J. C. Holm,<sup>2</sup> of Laurvig (Norway), who highly recommended the inhalation of nitrate of silver by a modification of the original method. To avoid the formation of the acid vapours, pure nitrate of silver was heated slowly with ammoniac

<sup>1</sup> *Ibid.*, 1875, p. 63.

<sup>2</sup> *Ibid.*, 1886, p. 191, and 1887, p. 39.

nitrate ; by this process the latter salt is decomposed into water and nitrous oxide (laughing gas) :



By the rapid development of the nitrous oxide the nitrate of silver is carried off in the same way as described before, and can be detected in the surrounding atmosphere by means of white paper. Dr. Holm found this method to be of great value in the treatment of simple chronic catarrh of the nose, the pharynx, the larynx, and the trachea, in cases of chronic bronchitis and of asthma, when the latter disease originated from the diseases of the upper air passages.

Further corroboration of the value of the inhalation of nitrate of silver in chronic catarrh of the respiratory organs has been quite lately published by Dr. Blomberg<sup>1</sup> of Christiania, and by Dr. Storch, of Copenhagen, the former author using an apparatus somewhat like the usual spray producers, but differing from them in that the atomized watery solution is highly heated before leaving the tube, so that only the dry fumes of the salt are inhaled.

According to all the above-mentioned authors the inhalation of nitrate of silver is of great value :

- (1) In cases of simple chronic catarrh of the nose, the pharynx, and the larynx ;
- (2) In cases of simple chronic tracheitis and bronchitis ;
- (3) In cases of emphysema when there is a considerable chronic bronchitis ; and
- (4) In cases of asthma, when originated from disease of the upper air passages.

(J. C. HOLM).

If we examine the above described method and its professed results more critically, the following objections may be raised. First, that the method is not new, but only a slight modification of the old well-known spray-inhalations with nitrate of silver. It must, however, be admitted that there is a considerable difference between the inhalation of a therapeutical agent dissolved in vapours of water, and the same suspended in the air in such minute and light particles as described before, for although experiments (Sales-Girons, Dumarquay, Moura-Bourouillon, &c.) have placed it beyond doubt that vapours of water *may* get far down in the bronchi by the usual spray-inhalations, still numerous clinical observations, combined with post-mortem examinations (Raminazini, Löwe, Brochmann, Graham, and others) and experiments (Knauf, Inns, and others), have shown that

<sup>1</sup> *Ibid.*, 1887, p. 40.

<sup>2</sup> *Hospitals-Tidende*, 1887, May 11 and 18.



solid bodies, suspended in the air in shape of dust, when inhaled reach down to the terminal ends of the bronchial tubes without any special respiratory efforts. Secondly, the objection may be raised that the effective agents set at work by the method are the gases developed, in the same way as the fumes of burnt nitrated paper act beneficially in certain forms of chronic bronchitis. The fact, however, that the same favourable results have been obtained by different investigators, using different plans of atomizing the nitrate of silver, make it doubtless that it is this remedy which acts on the mucous surfaces of the air passages. Thirdly, the method is not without risk for the patient, several times the inhalation has caused irritation of the lungs with cough and blood-streaked expectoration, and there seems even to be a danger of acute pneumonia arising from the irritation. Such cases seem, however, only to occur when the inhalations have been too prolonged (and patients are often inclined to remain too long in the inhalation room, feeling relief from the ease in breathing and expectoration), or the patients have inhaled cold air directly after the treatment. Another risk, worthy of attention, is also the possibility of producing a chronic silver poisoning, especially as some of the nitrate of silver undoubtedly reaches the stomach; this is a warning against letting patients use the inhalations themselves, or go on with the treatment too long. Finally, it seems unpractical to apply nitrate of silver to the mucous membranes of the upper air passages by means of inhalations, when the remedy can be much more effectively applied locally in solutions, powders, &c. This objection is, we think, at least for those well acquainted with the diseases of the upper air passages and their local treatment, of main importance, and will certainly considerably limit the adoption of the method by specialists.

On reviewing the advantages and disadvantages of the method of inhaling nitrate of silver, as introduced and practised by Scandinavian investigators, its great use in the treatment of chronic bronchitis and of emphysema seems so evident, and its drawbacks so slight, if but caution is observed, that it deserves a fair trial by other practitioners. As a treatment for diseases of the upper air passages, we hardly think it has any advantage over the methods previously known.

For those who should adopt the inhalations on the principles above described, we recommend the following plan as the most simple and practical. In the middle of a small room is placed, on a low table, a small Berlin crucible or evaporating pan, containing one part of nitrate of silver and three parts of ammoniac nitrate, and

under the cup is placed a spirit lamp, which heats it very slowly. The patients, who are sitting round the table, need not protect their faces, but linen or white clothing should be covered. Each inhalation ought not to last longer than thirty to forty-five minutes, and the treatment should not be extended over too lengthy a period.

H. M. (Copenhagen).

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## INSTRUMENTS AND THERAPEUTICS.

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**ALLEN, C. GLOVER** (N. Y.).—A New Snare and Ecraseur. *Méd. News*, July 16, 1887.

THIS is an original instrument, and apparently an improvement on the snares in general use. Its mechanism can only be understood by a study of the cut.

J. N. MACKENZIE.

**LABBÉ, EDOUARD**.—On a Method of Treatment of Whooping-Cough.

THE author has advocated local application of cocaine. This method does not cure the patient, but reduces the number and intensity of the attacks. At the present time Labbé recommends a treatment which is still more efficacious, and which consists of applications of an iodine solution to the entrance into the larynx. This method, employed by the author for twelve years, has always given good results.

JOAL.

**STORCH, O.** (Copenhagen).—On Inhalation of Nitrate of Silver as Treatment of Different Diseases of the Air Passages. *Hospitals-Tidende*, May 11 and 18, 1887.

GIVES a favourable report of the author's results of the above named treatment in cases of bronchitis and emphysema. (The method of inhalation described in *The Journal of Laryngology*, vol. i., No. 9, p. 321.)

**WICHMANN, G. L.** (Norway).—The Use of Lactic Acid in Lupus. *Tidsskrift for praktisk Medicin*, January 1, 1887.

THE author has successfully treated four patients with deep and large lupus-ulcers of the nose and face, by lactic acid in the following way:—The ulcers are covered with absorbent cotton soaked moderately in pure lactic acid, and over the cotton is placed oiled silk and then a bandage. If the surrounding tissue be quite normal, it is protected by grease or collodium, otherwise the acid produces blisters

on the epidermis; but as the effect of the remedy is lessened by grease, the author does not advise this to be used when there is the least suspicion of infiltration of the surrounding skin. The bandage is taken off after twenty-seven hours, and the ulcers washed, after which iodoform gauze is applied for two days. The gauze is then removed, and the same treatment repeated as often as necessary. The application of the lactic acid is rather painful, and not relieved by cocaine, but after one to three hours the pain generally ceases.

HOLGER MYGIND.

**BOSWORTH, F. H.**—The Practical Value of our Present Methods of Treating the Upper Air Passages. *Med. Record*, April 30, 1887.

IN the whole history of laryngology no case of so-called chronic laryngitis was ever cured by topical applications, whether made by sponge, brush, or spray. The more serious laryngeal affections, *e.g.*, tumours, syphilis, cancer, tuberculosis, paralysis, &c., of course no one ever claimed to cure by topical agents. Chronic laryngitis is merely symptomatic and secondary to disease of the nasal cavities in every case. Applications, especially astringents, to the lower pharynx for relief of chronic pharyngitis, however applied, do not cure.

There is no such disease as naso-pharyngeal catarrh in the sense of its being a catarrhal inflammation of the vault of the pharynx. The supposition that it is due to chronic inflammation of its lining membrane, with hypersecretion, is a myth. It is in reality diminished secretion. No local application behind the palate, by brush, sponge, or probang, ever mitigated the severity of so-called naso-pharyngeal catarrh. Neoplasms, hypertrophies of the pharyngeal tonsil, &c., can only be dealt with surgically.

Nasal catarrh is not a hypersecretion to be cured by astringents. The pathology of nasal catarrh is morbid condition of the mucous membrane interfering with the great respiratory function of the nasal passage, *viz.*, exosmosis of serum, and so-called catarrh of the pharynx, larynx, and trachea are merely secondary to this condition, and are not diseases in themselves, being amenable, only to treatment directed to the nose. Douches and sprays have never yet cured cases of catarrhal inflammation in the upper air passages.

The author has never seen any bad effects from the use of the nasal douche. Inhalations have deservedly fallen into disuse. Sprays have deservedly occupied the most prominent place in therapeutic resources. They are only helps, and no one form of spray or apparatus is better than another. Compressed air is of no advantage. A single bulb spray is better than the most expensive apparatus.

The treatment of catarrhal affections of the upper air-tract consists in the treatment of the nasal passages, the restoration of these passages to a normal condition by the removal of obstructing bone and cartilage, reducing hypertrophied membrane and correcting hyperæmia, &c., in other words "in the use of the snare, the saw, the knife, and the cautery." The simplest caustics, *e.g.*, chromic acid, possess advantages over the most cumbersome cautery apparatus. A crystal of chromic acid accomplishes all that the platinum wire can possibly accomplish, and does it better. [The author's views are original and represent one form of specialism—viz., the deification of the snare, the saw, the knife, the cautery. That the author's views are open to most damaging criticism will be obvious to all.]

**SMITH, ANDREW H.—Efficiency of Medical Treatment of the Diseases of the Upper Air Passages.** *Med. Rec.*, April 30, 1887.

THE author does not doubt that acute and subacute affections are favourably influenced by topical applications, such as anodynes for hyperæmia, the result of hyperæsthesia, astringents for hyperæmia without hyperæsthesia, stimulants for sluggish capillary circulation, and mild escharotics for abrasions and ulcers. The author is not so sanguine in cases of old chronic catarrhs. Of 1,773 cases treated at one of the largest throat clinics in 1886, 1,351 were cases of non-specific chronic disease. The number of operations undertaken was 370, or only 27 per cent. The rest were treated by topical means. Surgical treatment cannot therefore be made to take the place of other local methods, and when surgery has done all it can do, there remain nearly three-fourths of chronic throat and nose cases which depend for treatment upon topical applications.

Under the most favourable conditions all we can do in chronic conditions is to assist the reparative efforts of nature, and "when once glandular and vascular and interstitial changes have taken place in a tissue as the result of long continued irritation or inflammation, and the structure has thoroughly adapted itself to the new order of things, it may well be questioned whether there remains any tendency towards repair, and whether a change impressed upon the structures from without may not take any other direction as well as that towards the original normal condition." Simply securing cleanliness will ensure much good, and the constantly recurring acute exacerbations can nearly always be benefited by sedatives and astringents. Hygienic measures, and in some cases internal treatment, are of great value. Complete and permanent cures cannot be promised:

**THOMSON, W. H.** (New York).—**Therapeutics of the Upper Air Passages.** *Med. Record*, April 30, 1887.

The treatment of chronic diseases of the upper air passages should be directed to (1) the cognizance of cutaneous nerve associations in the causation and perpetuation of inflammations of the mucous membranes; and (2) local disinfection. Organs existing in symmetrical pairs (hands, feet, eyes, ears) are so closely associated in their vasomotor relations, that the same effect, so far as circulation is concerned, is produced on both by an impression made only on one member of the pair. Unsymmetrically placed organs (lungs, kidneys) do not show the same close nervo-vascular association. There is an association between the sensory nerves of any part of the skin with the vasomotor nerves of organs and viscera immediately within that part, so that like impressions on the cutaneous nerves produce like effects on the circulation of the inner structures. There are certain special vasomotor associations of widely separated parts which have no obvious functional connection with each other—*e.g.*, the vasomotor nerves of the feet and of the pelvic viscera, the association between the feet and the circulation of the pharynx and larynx, the nape of the neck and the nasal cavity (the close connection between abnormal innervations of the cervical nerves and congestions of the nasal cavity has not been sufficiently recognized).

Many persons with chronic mucous catarrhs are affected by influences wholly inappreciable by persons in health, and many with chronic nasal, pharyngeal, or laryngeal catarrhs have their troubles aggravated by nocturnal exposure in bed of the neck or back of the shoulder which a healthy person would not feel at all.

The application of cold, douching the nape of the neck, cold salt water sponging the throat should be kept up for months in all affections of the upper respiratory passages. Tendency to perspiration should be checked by rubbing with olive oil. Suitable woollen night and day clothing should be ordered, covered with a perforated buckskin shirt; partial protection—*e.g.*, chest protectors, is worse than useless. Local disinfection is the second desideratum, obtained in two ways:—1. Increasing the resistance power of the tissues; 2. Dealing with hereditary weakness. Cod-liver oil is an efficient nerve and cell feeder. The carbolic class of disinfectants are best for all suppurative disorders, and the chlorine class for necrotic affections. Insufflations of calomel and bismuth are used by the author in nasal catarrh, and for the pharynx, and are better, from their adhesiveness, than sprays.



**CURTIS, H. HOLBROOK** (New York).—**A Paper concerning a Few Points in Practical Laryngological and Rhinological Work.**

*Med. Record, April 30, 1887.*

DEDUCTIONS are based on observation on over 1,000 cases in which the author has practised enlargement of the upper air passages, by chromic acid applied to erectile tumefactions and true hypertrophies, and surgical interference to remove cartilaginous or bony obstructions caused by septal deflections, &c. Granular pharynx is due to mouth breathing, and any treatment directed to this condition without enlargement of the nasal fossa is misdirected. Chronic post-nasal catarrh unaccompanied by stenosis does not exist. Conditions which simulate this may be referred to disease of the ethmoid cells, especially the anterior group. This condition is due to hypertrophy of the middle turbinated bone closing the exit of ethmoidal secretions. Chromic acid is the remedy for this condition, and also for hypertrophies of the inferior turbinated bodies. "Burning the nose" and enlarging the upper air passages also improve the "timbre" of the voice in a magical manner. In the author's hands chromic acid applied to the nose becomes a panacea for all sorts and conditions of affections immediate or remote (laryngitis, spasmodic asthma, and bronchitis, acute or chronic, amongst others). He relates how singers wishing to appear to great advantage have come to him to have the brilliancy of tone restored by application of chromic acid to the turbinated bodies, and the author has repeatedly done this when there was "no necessity for the operation." He has never seen bad effects from the use of chromic acid. It is to be smeared on one side of a copper applicator, and Dobell's solution in spray used a few moments after. The author concludes with the expression that "the sooner the farce of applying strong astringent solutions and nitrate of silver is done away with" (and shall we say, replaced by the farce of applying chromic acid indiscriminately?), "and proper appreciation given to the magnificent results obtained by restoring the function of respiration as nature intended, the sooner laryngology will be placed on a higher plane, and an immediate relief given to countless thousands who imagine an incurable so-called post-nasal catarrh."

**JARVIS, W. CHAPMAN** (New York).—**Topical Application to the Upper Air Passages.** *Med. Record, April 30, 1887.*

THE value of the spray has been greatly over-estimated. It is most useful for cocaine applications, and is useful occasionally for cleansing.

Is the only means for applying rhigolene anæsthesia, is useful for applying vaseline preparations, and for projecting medicated powders. Coarse sprays are one of the most effective means for nasal cleansing. The syringe is often to be preferred to the spray. Compressed air is best for powders, especially iodoform. Surgical methods are mostly to be preferred for the treatment of catarrhal processes in the nasal cavities, which are due to nasal obstruction in the vast majority of cases. Dr. Jarvis cannot agree with the use of chromic acid for removal of turbinated hypertrophies, not doubting, however, that it can remove hypertrophies if persistently applied, but it is not the best agent for this purpose. Transfixion and the snare *écraseur* will remove the redundant tissue in a few minutes. The same objection applies to the galvano-cautery. He has also seen severe annoyance from traumatic rhinitis to extensive inflammation of the post-nasal structures and œdema of the soft palate from the use of chromic acid.

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## DIPHTHERIA.

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**Report of Dr. George Turner's Experience of Diphtheria, especially in its Relations to Lower Animals, partly obtained in the course of Inspections made for the Board (Local Government Board) in 1886. *July, 1887.***

OUR knowledge of the etiology of diphtheria is notoriously imperfect. The report of Dr. Turner is so full of suggestion with regard to this question, that we herewith present it as it is published, in the hope of stimulating inquiry in this direction. If any readers of this Journal will supply us with duly accredited facts bearing on this etiological question, we shall be pleased to report them in the Journal with due acknowledgment.

Almost nothing is with certainty known of the beginnings of diphtheria, though much has been learned respecting conditions favouring its spread and something, perhaps, of influences fostering its virulence.

The earliest cases in an epidemic of diphtheria are frequently very mild, and thus easily escape recognition. The first persons to die (almost invariably children) are generally supposed to have suffered from "croup," and very likely at commencement of an epidemic diphtheria may be mainly a local disease, killing rather by suffocation than by general "blood poisoning."

In villages and towns diphtheria beginning in the above fashion is, without question, often subsequently propagated by personal communication, especially by association of children in school. And, seemingly, at school slight cases of diphtheria and cases that are convalescent get opportunity for passing on the malady, with great addition of intensity, to other persons. It has been found, too, that when a school has been closed on account of prevalence of diphtheria among the

scholars, the disease sometimes recurs again and again after re-opening of the school, as a result of the premature return there of children convalescent or seemingly quite recovered of their illness. Convalescent children do not seem to do much harm in their own families, but as soon as a few of them congregate in school the diphtheria is apt to reappear with all its old severity. Of other influences tending to enhance severity of diphtheria, unwholesome circumstances of dwellings have been thought of as especially potent. Thus overcrowding, badly trapped drains, and damp walls and floors have been cited as influencing the course of attacks of the disease unfavourably. In my own experience saturation of the soil under the dwelling with fecal matter, or with water contaminated by excrement, has appeared a condition especially favourable to development of diphtheria in its most fatal forms.

But cases of diphtheria occur for which neither personal communication nor any of the above conditions can be assigned as probable causes. It is of these that I desire more particularly to speak. They are cases especially difficult to account for, from the very fact that they are confined to one or two families, and we cannot compare the daily life of those who escape and of those who are attacked to see in what respect their lives have differed, and so arrive at the cause of the mischief. Still an attempt at this may be made by comparing a number of isolated cases.

In regard to cases of the above sort, I am about to raise afresh the question as to probable origination of diphtheria in the human subject by means of lower animals: relating my own experiences in this connection since 1882, when the matter began to especially engage my attention.

A hypothesis of relation of human diphtheria to disease of lower animals is by no means a gratuitous one. On the contrary, it has much to recommend it. Thus communication of anthrax and glanders from lower animals to man has long ago been established, and we know of transmission to the human subject of scarlatina, diphtheria, and enteric fever by cows' milk. It is true that for years it has been assumed by some persons that these diseases must needs have been communicated from man to man through the medium of milk, rather than directly from the animal to its milk; but recently Dr. Klein has demonstrated that a disease of the cow, causing the animal apparently little or no discomfort, can, when the creature's milk is consumed by human beings, reproduce itself in them as scarlatina, one of the best known and most fatal of infectious disorders. The cow disease here in question is so trivial as to escape the notice of persons accustomed to the care and treatment of cows, and its clinical identity with scarlatina can be altogether denied on veterinary authority. I am encouraged, therefore, in what follows to be content with drawing attention to none but broad clinical and pathological resemblances between maladies of lower animals and diphtheria in the human subject.

That I am unable to demonstrate conclusively the transmission of diphtheria from the lower animals to man, or from man to the lower animals, I am perfectly aware. I have never been in a position to do this experimentally with much chance of success. The evidence I have to offer is only circumstantial, and is therefore open to numberless objections, but it will, I hope, be sufficient to induce medical officers of health who may have opportunities of witnessing the commencement of extensive epidemics, or those single cases which occur in isolated positions amongst persons little exposed to infection in the ordinary way, to take the matter up and inquire into the possibility of the occurrence I am mentioning.

In the year 1882 a *pigeon* was brought to me for dissection. From the history of the symptoms I hoped to find strongles in the trachea, specimens of which I was anxious to obtain. To my surprise, I found the whole of the windpipe covered with a well-marked consistent membrane, which hung loosely in the tube like a windsail, just as one may see it in the body of a child who has died of croup.

A person, whose name I need not mention, inoculated pigeons in the fauces with this membrane. A disease of a similar character resulted, showing that the disorder was communicable, and he noticed that the affection extended up into the eye of the pigeon through its nostrils.

In 1883 an epidemic of diphtheria occurred in the village of Braughing. The first cases were connected with a farm on which the *fowls* were dying of a disease seemingly identical with that above referred to as affecting pigeons; and diphtheria made its appearance on other farms, where it was also preceded by a similar affection amongst the fowls. I subsequently noticed the same association in other instances, and during the summer of 1886, while making inquiries, for the Local Government Board, into the circumstances attending epidemic diphtheria at Farnham, I found that the fowls had been affected at the same time as human beings in Aldershot, where a veterinary surgeon dissected some chicken and noticed the presence of a membrane in the trachea. It had occurred too amongst *turkeys* and fowls at Ash; at Long Eaton, in Derbyshire, it had been very prevalent; while at Tongham and its neighbourhood (in Surrey) it caused great havoc amongst chicken and *pheasants*.

At the last-mentioned place a gamekeeper employed rearing game and chicken described very clearly the appearances he had noticed in his birds; the white crusts round the beaks, the patches in the throat, the invasion of the eyes and nostrils, and the absence of strongles,<sup>1</sup> *Sclerostoma syngamus*. At Tongham, too, a man bought a chicken at a low price from an infected farm, because it was likely to die of this diphtheria-like disease. He took the bird home, and diphtheria itself broke out in his house shortly after; this was the first case in that village. My attention was called to these facts by the medical attendant, and the man himself corroborated the information in all particulars. I have also seen chicken and pigeons which have been inoculated\* with diphtheritic membrane from a child's throat attacked with a disease which in all respects resembled what I regard as natural fowl-diphtheria.

Similar accounts are received from abroad,<sup>2</sup> so that the identity and transmissibility of this disease from fowls to men seems very probable.

My attention was at first directed almost exclusively to what I regarded as diphtheria amongst fowls. I had observed a disease in swine which appeared exactly similar to human diphtheria, and had noticed that at Braughing both the *swine* and *horses* suffered from sore-throat sickness immediately after the epidemic amongst the human beings. But until 1886 I had seen no reason for supposing any disease of a similar nature was communicable by swine or horses, or indeed by *cats*, to mankind. During the month of January, 1886, however, I was called upon to investigate an epidemic of diphtheria at Brent Pelham (Herts), and found that in the cottage in which the first cases occurred a *kitten* had previously suffered from a throat affection, which was attended by swelling of the neck, foul discharge from the nostrils, and "running" at the eyes. Before I arrived on the spot the kitten had died and had been buried. I dug it up, but decomposition had advanced too far to admit of its being employed for purposes of experiment. Other cats at Brent Pelham were found to have suffered in a like manner. That the animals had not been shot at and wounded was ascertained, because they had been seen and handled; and as far as it was possible I assured myself that they had not been poisoned. Two cats had died at the general shop in the village; I offered the shopkeeper 10s. for a cat suffering in a similar

<sup>1</sup> The possibility of diphtheria amongst fowls being mistaken for strongles or the gapes is very great unless the birds are seen; but only the very young chicken usually succumb to the animal parasite, while numbers of the older birds die from this other disease.

<sup>2</sup> *British Medical Journal*, October 16, 1884; *Journal d'Hygiène*, 1884, p. 411.



manner, but although one was subsequently attacked he preferred to kill and bury it rather than let me have it. This man subsequently himself suffered. Similar disease was noticed amongst the cats at Aldershot in Hants, at Farnham and Yateley in Surrey, and at Petersfield in Sussex. In the latter town the evidence was very clear, not that the animal had communicated the disease to certain children, but that it had been infected by them. The cats in a row of houses in which the disease had been prevalent were noticed to be ailing, their throats were swollen and there was discharge from the eyes and nose. Moreover, one woman informed me that when her cat was recovering it experienced a difficulty in taking milk, and that it choked and sneezed when attempting to do so. At Moulton (Suffolk) some children were ill of diphtheria in a cottage at some distance from the village. They had been infected while attending the village school, and were by the direction of the medical man confined to the upper rooms of their cottage that the other inmates might escape. No food which had been offered to the sick children was set before the others, the mother habitually gave it to the cat. The animal subsequently suffered to such an extent that it became a question whether it had not better be killed; this was not done, and the cat eventually recovered. At Blackwater (Surrey) I spoke to a medical man in practice there, who told me that he had never remarked any occurrences of the above sort, but would in future make inquiries in that direction. I have subsequently received from him a short note of a case in which children were attacked with diphtheria after their cat had been ill. (In the *British Medical Journal*, January 3, 1885, there is an account of some experiments by Dr. C. J. Renshaw, who appears to have succeeded in inoculating cats with diphtheria, using for his purpose diphtheria-material from the human subject.)

*Horses*, it is well known, suffer from sore throat, one variety of which is called "strongles"; but diphtheria does not appear to be recognized as a disease occurring amongst them. Without asserting that strongles is in all cases diphtheria, I think it is possible that some of the many diseases classed under that name may have kinship with the human diphtheria disease.

At Moulton the first case of diphtheria at a farmhouse occurred shortly after a horse on the farm had died of strongles; the second was that of a man working on the farm as "horse-keeper"; and in the neighbouring village of Ouseden, where a man who had recently recovered from diphtheria was for a short time employed to groom a mare, the animal in question was in a few days affected with "strongles," as shown by much swelling at the angle of the jaws, and a very foul discharge from the nose. At Yateley diphtheria in the human subject was in two instances coincident with "strongles" amongst the horses. Other instances of a similar character have come to my knowledge, and if the nature of the employment pursued by persons (or their parents) who have died of diphtheria be noted, it is surprising what a large proportion will be found to have followed occupations more or less connected with horses, or other of the lower animals. Commonly they are grooms, blacksmiths, or shepherds.

Dr. Ogle informs me that he met with an instance in which diphtheria occurred in a shepherd's family shortly after a throat disease had prevailed amongst the *sheep*. An epidemic at Portsmouth was preceded by a great mortality amongst the *lambs* in the surrounding country, and the reports of the Medical Department of the Local Government Board contain at least one other instance in which it seems probable that diphtheria had been communicated to the human subject by sheep. At Moulton I was asked to see a flock of sheep and lambs said to be suffering from a throat affection; I formed the opinion that they were suffering from foot-and-mouth disease, but although I have seen that disease very frequently



in cattle I have had no experience of it amongst sheep, and may have been mistaken. The shepherd affirmed it was nothing of the kind.

I think there is sufficient evidence to encourage careful inquiry as to connection between diphtheria in man and throat affections amongst animals. It is a question of great importance, and demonstration of such connection would help to explain the occurrence of cases of diphtheria in isolated positions where human communication is very restricted. As for instance in the Australian bush, where, as I am informed by a friend residing there, diphtheria sometimes makes its appearance under circumstances which almost preclude any conveyance of infection by human beings or by prevailing winds.

It might explain, too, the great difference we notice in the severity of diphtheria in different epidemics, and make clear other facts concerning which we are at present totally in the dark.

**BLANCO.—Diphtheria.** *Correspondencia Médica, March 16, 1887.*

THE author claims to have obtained wonderful cures by administering Guttman's potion internally, and painting the patches with the following solution :—

R Lime water	...	...	...	100 parts.
Chlorate of potash	...	...	...	10 „
Phenate of soda...	...	...	...	2 - „
RAMON DE LA SOTA.				

**ARBOLEZA.—Internal Use of Copaiba in Diphtheria.** *Correspondencia Médica, March 16, 1887.*

THE author recommends this plan of treatment.

RAMON DE LA SOTA.

**VARELA.—On the Treatment of Diphtheria.** *El Genio Médico-Quirúrgico, February 7, 1887.*

THE author claims that ninety out of every hundred patients are cured by using cauterizations of concentrated solution of sulphate of copper ; insufflations of alum ; and internally, chlorate of potash.

RAMON DE LA SOTA.

**MATA, GOMEZ DE LA.—Diphtheritic Quinsy and Croup.** *Los Avisos Sanitarios, June 20, 1887.*

THE author points out the modifications which he has introduced into the treatment of this disease. He administers internally, every two hours, a teaspoonful of the following potion :—

R Distilled water	...	...	...	80 grammes.
Pepsin	...	...	...	1 gramme.
Hydrochlorate of pilocarpin	...	...	...	5 centigrammes.
Hydrochloric acid	...	...	...	2 minims.

He applies to the pharynx lemon juice and salt, and uses syrup of ipecacuanha as an emetic. The author says that by this method he

has cured a few cases of pharyngeal diphtheria, but could not succeed with a case of pseudo-membranous laryngitis.

RAMON DE LA SOTA.

**GONZALEZ, ALVAREZ.**—Pharyngeal Diphtheria treated by the Thermo-Cautery. *Archivos de Medicina y Cirugia de los Ninos* Ano III., No. 30.

A GIRL, eight years old, presented in the centre of the inner surface of left tonsil a patch nearly circular, whitish grey, with thickened borders well defined, under the size of a fifty cent silver piece. On rubbing, it became loose in some parts, blood oozing from the exposed surface. There were no submaxillary swellings. The author applied the thermo-cautery needle to the false membrane, and afterwards repeated the operation in order to limit the intensity of the secondary inflammation, which, however, was slight. Cold gargles were used. At the end of three days the slough was loosened, and the place remained well. The author believes this case to be one of true diphtheria, since by rubbing the white patch with the finger the latter was folded up like a piece of paper and a bleeding surface remained exposed.

RAMON DE LA SOTA.

**MASSEI.**—Nasal Diphtheria, and Secondary Forms of Diphtheria. *Gaz. Med. di Torino*, 1887.

THE author, in a recent lecture, took up the ground that it is not possible, either from the point of view of bacteriology, or from clinical evidence, to determine that the exudative sore throat of scarlatina is part of the morbid process itself, or really a diphtheritic complication. He inclines to this latter opinion, insisting on the fact that the special bacilli described by Klebs and Loeffler are by no means constantly found in undoubted diphtheritic products, and the presence or absence of these organisms cannot, therefore, give any important aid to diagnosis.

MASSEI.

**GONZALEZ, ALVAREZ.**—Individual Prophylaxis of Diphtheria. *Archivos de Medicina y Cirugia de los Ninos*, Ano III., No. 30.

THE author believes diphtheritic infection to be local in origin, and that the sore throat prevents the epithelium from protecting the chorion and vascular networks, thus facilitating the ingress of the infectious germ, whatever it may be. In order to maintain the epithelium in a healthy condition, and to cure existing erosions, the author administers to children four or six times a day (and according to age), a spoonful of chlorate of potash, and he affirms that of a hundred and fifty-six children in his private practice, only one was attacked with diphtheria, and that very slightly, and entirely through

neglect of prophylactic means. All the rest preserved good health, although they had been put together with diphtheritic patients. In the hospital for children no infection whatever took place among those taking chlorate of potash, and at the Foundling of Madrid, where the medicine is frequently used, no case of diphtheria has been registered, even although the disease prevailed endemically all over the town.

RAMON DE LA SOTA.

## TONSILS, PHARYNX, &c.

**SCHADEWALDT** (Berlin).—On the Localization of Sensations in the Organs of the Throat. *Deutsch. Med. Wochenschr.*, Nos. 32, 33, 1887.

SEE the report of the subsection of laryngology in the meeting of naturalists and physicians, Berlin, 1886. This Journal, vol. i., p. 81.

MICHAEL.

**KEIMER** (Düsseldorf).—Case of Angioma Varicosum of the Soft Palate, of the Left Tonsil, and the Anterior Palatine Arch cured by Electro-puncture. *Deutsch. Med. Wochenschr.*, No. 33, 1887.

THE title indicates the case.

MICHAEL.

**LUBLINSKI, W.** (Berlin).—Tuberculosis of the Tonsils. *British Med. Journ.*, August 27, 1887.

THIS is a rare disease. No cases have been recorded in which isolated tuberculosis of the tonsils has been clinically observed. The author relates two cases in which, however, the disease was secondary to pulmonary tuberculosis. Tuberculosis of the tonsils, as a primary condition, has not been observed in man, though noted in animals fed on tubercular material.

The tonsillar tubercles described by the author in his cases were ulcerations of about the size of a lentil, the bases of which were covered with whitish detritus, and the margins of which were slightly raised, and redder than the surrounding parts. These tubercular tonsillar growths seldom break down.

Treatment must consist in destruction of the tubercles by the galvano-cautery, or covering the ulcerated surfaces with iodol.

GREVILLE MACDONALD.

**POSHENYSKI, P.**—Ligature of the Common Carotid of the Left Side for Ulceration of the Internal Carotid, consequent upon Phlegmonous Amygdalitis. *Gaz. Med. di Roma*, 1887.

THE case was one of intense phlegmon of the left tonsil, with exten-

sion to the velum and surrounding parts. Spontaneous opening occurred, with copious hæmorrhage, which, although a tampon was used, recurred. The operator, considering the dangers to which he would expose the patient by ligaturing only the external carotid, and recalling the vascular anastomoses, decided to ligature the common carotid. A good recovery without any cerebral symptoms resulted, but twenty days after the operation the patient died. MASSEL.

**SEIFFERT.**—Clonic Spasms of the Soft Palate with Objective Ear Noise caused by Chronic Rhinitis. *Internat. klin Rundschau*, 1887, No. 29.

THE author observed a case similar to that of Schech, referred to a short time ago in this Journal. A lady twenty-eight years old was treated for a nasal catarrh by the galvano-cautery. When she came under the treatment of the author she had a dry nasal catarrh and clonic contractions of the whole of the muscles of the face. She also had clonic contractions of the soft palate and of the Eustachian tubes. Not only she herself could hear a cracking noise, but also other persons near her could hear it. She was treated with chromic acid but without result. (The reporter has also observed such a case. It was a lady of forty years of age who had nasal polypi. By unsuitable application of the galvano-cautery the openings of the Eustachian tubes were burned without removal of the polypi. For some years there resulted clonic spasm of the Eustachian tubes, with an objective and subjective cracking noise in the ear. The reporter removed the polypi with the cold wire, and the noise disappeared some months later.) MICHAEL.

**BROWN, BEDFORD** (Alexandria, Virginia).—Erysipelas of the Pharynx and Larynx, Epidemic and Sporadic. *Journ. of the Am. Med. Ass.*, July 2, 1887.

THE author enters at length upon the etiology, diagnosis, symptoms, prognosis, and treatment of this affection, and gives one of the most practical, original, and thorough accounts of the disease with which we are acquainted. Speaking from the standpoint of twenty-nine years' experience, he pronounces erysipelas of the throat one of the most fatal of throat diseases, the mortality frequently ranging between 70 and 80 per cent., and even going up to 90 per cent. In the treatment, time is a vital consideration. Local applications of iodine, silver, and simple astringents are useless and deceptive. The internal use of quinia and iron is impotent for good. The indication is to produce promptly and efficiently an extensive counter irritation, and sudden dilatation of the cutaneous capillaries over the seat of

the internal erysipelatous affection, thereby relieving the enormously engorged structures, and preventing glottis closure. This is best produced by sinapisms extensively used. Epispastics—ammonia, oil of turpentine, &c.—are inadmissible, as they establish inflammatory action sufficiently violent to cause gangrene of the skin. By pursuing the method of rapid revulsion tracheotomy has been repeatedly averted. The latter operation is not suitable to erysipelatous affections of the fauces. The disease generally attacks the tracheal wounds. Internally, the author speaks highly of the salicylate of ammonia, especially when there exists a tendency to brain trouble.

J. N. MACKENZIE.

**ARIZA, RAFAEL.**—Granular Pharyngitis—Follicular Laryngitis—Tonsillar Hypertrophy—Treatment. *Annales de Otol y Laryngol*, Nos. 1 & 2, 1887.

ARIZA speaks of the great frequency with which these affections appear in both sexes, and the inability to assign any sufficient causation, since causes referred to—alcohol, tobacco, irritating substances, crying, unhealthy atmosphere, dust, cold, &c.—can only be considered as secondary; rheumatism and herpetism being the most important determining cause. The granular sore throat exists *ab ovo* in all persons of either sexes, whether lymphatic and sanguineous, bilious and nervous, amongst those who complain, and those who do not complain of their fauces. The granulations are either large or small, secretory or non-secretory, pink or red, with or without varicose vessels, upon a mucous membrane normal, reddish or marbled, atrophied and sunken, or tumid and projecting. In all cases seen by Ariza there has been a sensation as of a foreign body, a desire to eject it, great heat, pricking, and the characteristic "Ahem," and a useless swallowing to overcome the feeling of dryness. A hyperæsthetic pharyngitis does not constrain swallowing, a point which the author considers differentiates it from acute tuberculosis of the fauces. It can, however, be mistaken for the chronic form, but in this there is a slow and constant, although slightly graduated pain, without exacerbations and with relief which is evident only at the end of one or two weeks. In the tubercular sore throat round ulcers occur, painful to the touch, but do not exist in the hyperæsthetic form; chronic catarrh of the pharynx frequently extends to the larynx; and besides the catarrhal condition of the vocal cords, more or less paralysis of the thyro-arytenoid muscles is often observed. Hypertrophy of the tonsils is only a form of granular pharyngitis. Treatment is very easy, but cure is difficult. The parts should be washed every day with saline and antiseptic fluids, and afterwards be touched with glycerine containing iodine, tannin,



carbolic acid, or creosote ; or with a solution of nitrate of silver (10 per cent.), or the granules should be cauterized with chromic acid, or the galvano-cautery. The secondary laryngitis yields easily to applications of nitrate of silver. The tonsillar hypertrophy is successfully treated with the galvano-caustic snare and sharp pointed knife.

RAMON DE LA SOTA.

**MASUCCI.**—**Contribution to the Knowledge of Legal's Disease.**

*Giorn. Internaz. delle Sc. Med.*, 1887.

THREE cases of the above disease are related—*i.e.*, temporo-occipital cephalalgia of pharyngo-tympanic origin, chronic inflammation of the pharynx extended through the Eustachian tube to the middle ear. This condition is sometimes the only cause of obstinate neuralgia, and this subsides quickly if rational treatment is adopted. Similar cases met with by Masucci, and then unintelligible to him, become explicable in the light of Legal's researches. The author does not venture upon a pathological explanation of the disorder, but affirms that he obtained much success in treatment from the employment of nasal douches of compressed air, as first recommended by Massei, combined with local treatment.

(It is questionable if it is desirable to elevate a symptom into a special disease.)

MASSEI.

**FOURNIER, A.**—**Recurrent Herpes of the Tongue in Syphilitic Subjects.** *Semaine Méd.*, July 13, 1887.

IN the mouths of syphilitic subjects there frequently occurs an affection of quite a special kind, consisting in successive crops of multiple small erosions which are distinctly herpetic. These lesions are never met with in the condition of herpetic vesicles, most probably because these vesicles are essentially ephemeral, and are destroyed as soon as formed. But the erosions which follow them have so clearly the character proper to herpes, that their nature cannot be mistaken.

In the mouths of such patients is produced something analogous and identical with what is produced on the genital organs—*i.e.*, recurrent herpes of these organs. Recurrent herpes of the mouth owes its origin to the same irritations causing buccal syphilides—mercurialism and tobacco. Diagnosis was important in this case, for it was necessary to abstain from mercurial treatment, and there was no cause to prohibit marriage.

JOAL.

**KURZ** (Florence).—**Stricture of the Œsophagus. Death from Pleuritic Perforation.** *Deutsch. Med. Wochenschr.*, No. 34, 1887.

A BOY of four years old had a stricture of the œsophagus from swallow-

ing sulphuric acid. The stricture was so tight that fluid could only be swallowed with great difficulty. The boy became suddenly highly feverish, and died thirty-six hours later. The autopsy revealed an abscess perforating the œsophagus, the thymus, the mediastinum, and communicating with the left pleural cavity, which was in a state of high inflammation and filled with sero-purulent fluid. MICHAEL.

**LE DENTU.**—Note on Internal Œsophagotomy at Multiple Sitzings. *Acad. de Méd., June 28, 1887.*

THE instrument devised by Maissonneuve is dangerous, especially on account of the size of its blades ; he has therefore devised a series of blades of graduated sizes, the smallest being five millimètres, and the largest nine millimètres. He has applied these graduated blades in the case of a man of thirty, who had a stricture twelve centimètres long, and which only permitted the passage of a No. 11 urethral bougie. A first section was made with the smallest blade, and dilatation was thus rendered possible. JOAL.

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## NOSE AND NASO-PHARYNX.

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**MACKENZIE, JOHN NOLAND** (Baltimore).—A Contribution to the Pathology and Treatment of the Respiratory Vaso-Motor Neuroses. *New York Med. Journ., February 26, 1887.*

THE upper respiratory tract (nasobronchial) is the seat of periodical vascular disturbances in which paroxysmal explosions of nervous force, sympathetic or vaso-motor, play a conspicuous part. The whole tract or only a portion may be thus affected.

The two factors are, depraved condition of nerve centres, and abnormal excitability of certain portions of the naso-bronchial tract. It may be hereditary, or acquired,—e.g., from prolonged irritation (nasal congestions, inflammation, polypi, chronic affections of the larynx, pharynx, and bronchi), leading to repeated and continuous vascular disturbances over certain areas (erectile tissues of nose), with subsequent irritation of nerve centres. These centres then come to be hyper-excitabile. Any peripheral or central cause will then excite a paroxysm. Neurasthenia is another cause ; certain diathetic conditions also lead to abrogation of the functional activity of these centres. Intense hyperæsthesia of the respiratory membrane, like the vascular engorgement, is secondary, occurring only from central irritation or paresis. This is brought about by direct impression upon the terminal nerve filaments, by indirect influence

conveyed or reflected through the vaso-motor centres from a distant organ, or from excitation starting in the centres themselves. The hyperæsthesia may be general or localized in segments, as in the lower and posterior portions of the nostril, the pharynx, the vault and posterior wall; the laryngeal interarytenoid commissure, and the posterior wall of the trachea, always in the lower and posterior portions of the respiratory tract. These affections are intimately related to some disturbance of the sympathetic nerve, and probably a deranged condition of the vaso-motor centres themselves.

The author then refers to an undescribed neurosis of the aural apparatus, closely allied in etiology and mechanism, &c., to vaso motor coryza. It is a sort of hay fever of the ear. He refers to Gradle's case of periodical affection of the conjunctiva analogous to hay fever. In vaso-motor coryza it is the spheno-palatine ganglion, in the aural neurosis the otic ganglion, in Gradle's recurring conjunctivitis the ophthalmic ganglion which is at fault. He then discusses asthma in relation to nasal disease. It is not generally known that Ferber, of Hamburg, in 1869, referring to the frequent association of sneezing, migraine, bronchial asthma, and hay fever, advanced the theory that they were a neurosis of the trigeminal brought about by circulatory disturbances in the lower pelvis. Ferdinand Wydler was also a pioneer in this question of nasopharyngeal reflexes. The author then speaks at some length of "hay fever," coryza vaso-motoria periodica and treatment of the same, and condemns the too frequent use of cocaine as leading to increased irritability of the structures and permanent dilatation of the erectile tissues. This affection is to be treated, as any chronic disease of the nervous system, with tonics, and he insists on the treatment being kept up in the intervals of the attacks, especially recommending phosphorus, zinc, quinine, and nux vomica, Fowler's or Donovan's solution (of arsenic), the bromides, or the constant current (one pole over of the nape of the neck, the other over the superior cervical ganglion and nasal passages). Treatment of the nasal cavities only closes one door against irritation of the nervous centres. Those who rely upon removing obstructions solely, do so on incomplete pathological grounds. Behind all these factors stands the neurosis.

**INGALS, E. F.** (Chicago).—**Epistaxis.** *Med. News*, July 23, 1887. ONE of the best means of checking nasal hæmorrhage is to syringe out the nose with cold water, and then insufflate a powder containing a small amount of cocaine, which should be followed at once by powdered alum. After the powder has been applied, the nostrils

should be compressed or plugged. The author has known of one case in which posterior plugging produced inflammation of the mastoid cells. A method of plugging recommended by the author is to take a piece of surgeon's gauze, or cheese cloth, an inch in width and four or five feet in length, saturate it with a thick mixture of tannin, and introduce it, fold upon fold, into the nostril. If iodoform be used in connection with the tannin, the plug may remain for two or three days without danger. The author gives the principal causes of epistaxis, reports five cases of practical interest, and recommends highly the local use of the galvano-cautery and solid silver stick to the bleeding points.

J. N. MACKENZIE.

**ECHEVARRIA.**—Uncontrolled Epistaxis. *El Dictamen*, June 30, 1887.

A MAN, sixty-two years old, had experienced during some thirteen years several severe attacks of epistaxis, which had led him to the verge of death. His physicians had declared him to be hæmophilic. The author being called in to control the last hæmorrhage, plugged the nares anteriorly and posteriorly without success. Applying a blister over the hepatic region, the flux of blood was arrested. The author relates that his patient had neither hepatic lesions nor any sub-diaphragmatic circulatory condition which could have explained the epistaxis, and that there was no history of anything but hæmophilia. From this he infers that the *rationale* of blistering the hepatic region is not so obvious as it would be in existing chronic hepatitis, cirrhosis, or other lesion of this viscus, to which a great influence in the production of epistaxis has been attributed.

RAMON DE LA SOTA.

**CHATELLIER.**—Perforating Canaliculi of the Basal Membrane of the Hypertrophied Nasal Mucous Membrane. *Annales des Mal. de l'Oreille, Larynx, &c.*, June, 1887.

CANALICULI traverse the nasal membrane perpendicularly to its surface. Their external extremities open in funnel shape immediately facing the deep layer of the investing ciliated epithelium. When this epithelium is detached, one sees more clearly the opening of the canaliculi. The intermediary portion crosses the thickness of the basal membrane in rectilinear, sometimes in sinuous, direction. The opposite end of the canaliculi corresponds to the deep layer of the basal membrane. At this point the canaliculi are continuous with a network of canals in the substance of the mucosa immediately in contact with the deep layer of the basement membrane. Hitherto these canaliculi have only been seen in nasal mucous

membrane affected with hypertrophy. They also exist in the healthy mucosa. JOAL.

**HOPMAN** (Cöln).—What shall we call Nasal Polypi? An Answer to Different Criticisms of my Classification of the Benign Nasal Polypi. *Monatschr. für Ohrenheilk.*, No. 7, 1887.

POLEMICAL article.

MICHAEL.

**MICHEL, CARL** (Cöln). On Electrolytic Treatment of Fibro-Vascular Nasal Polypi. *Monatschr. für Ohrenheilk. &c.*, No. 5, 1887.

AFTER communicating four cases treated with good results, the author describes his method of operation. The needles are of yellow copper, one and a half mm. thick. A thin aural catheter covers the upper parts of the needles. These being soaked in oil before the operation, are introduced by rotatory movements. The author uses Stöhr's apparatus. After the operation the negative needle is easily removed, but the positive needle is destroyed by the oxygen, and is often rather difficult to remove. The patient must respire by the mouth during the operation. He can himself keep the needles in position. After a few days the destruction of the tumour can be seen by its discoloration. In six to nine months the largest tumours can be destroyed. The operation is not so dangerous as the galvano-cautery. MICHAEL.

**MOURE.**—Indurated Chancre of the Right Nasal Fossa. *Rev. Mens. de Laryngol.*, July, 1887.

PRIMARY manifestation of syphilis in the nasal fossa is rare, the only published case (*in extenso*) being that of Spencer Watson's, in which a nurse was affected, the chancre being situated at the inner surface of the left nasal ala. In Moure's case the right nasal ala was raised by a fungous mass of reddish aspect at certain points, greyish at others, where it was covered with pultaceous mucus. The tumour, which was situated on the septum, almost projected from the orifice of the nasal fossa, which it filled up internally, and extended to about two centimètres in backward direction. The submaxillary glands of the right side were tumefied. The patient has also presented mucous patches in the throat, and a papular eruption of the skin. JOAL.

**STRAUCH** (Herrnstadt-in-Schlesien).—Researches on a Micrococcus, in the Secretions of the Naso-Pharynx. *Monatschr. für Ohrenheilk.*, Nos. 6, 7, 1887.

A VERY praiseworthy bacteriological research, which, however, must be read in the original, not being capable of condensation into a short report. MICHAEL.



**SPICER, SCANES.**—On Distension of the Nasal Arch (Transverse Nasal Vein) in Children; its Pathology and Treatment. *Brit. Med. Journ.*, August 27, 1887.

CHILDREN with this condition (seen in the black distended vein at the root of the nose and overfilling of neighbouring superficial veins) suffer from intractable chronic catarrh of the nose and pharynx, often with swollen middle turbinated bodies and rhinorrhœa; and chronic congestion or hypertrophy of the post-nasal mucosa, and frequently post-nasal vegetations. The condition is produced by obstruction to the venous outlet, through the spheno-palatine foramina and pharyngeal collaterals. It is a sign of disease of the post-nasal space, and leads to disease of the nasal turbinated bodies, impairment of nutrition of the bony and cartilaginous framework of the nose (causing the latter to remain sunken and ill-shaped), to headache, drowsiness, and a heavy appearance. The condition is often cured by removing the post-nasal vegetations, or scraping off the hypertrophied post-nasal mucosa, especially in the region of the spheno-palatine foramina, this treatment being followed up by local application of some astringent pigment to the post-nasal space. Hygiene and good diet are important.

GREVILLE MACDONALD.

**INGALS, E. F.** (Chicago).—Suppurative Inflammation of the Antrum. *Journ. of the Am. Med. Ass.*, July 30, 1887.

GIVES an account of the symptoms and diagnosis of antral suppuration, and reports six cases coming under personal observation. Care should be taken not to confound the disease with suppuration of the ethmoidal cells, the absence of pain in the cheek, and of dental disease being in favour of ethmoidal trouble. Ingals very correctly prefers the operation through the alveolar process, with subsequent thorough drainage of the antrum. In three of his cases the operation was performed with eminent success. The opening is best made with a bone drill, and care should be taken to hold it so that as it enters the cavity it may not plunge suddenly through and wound the opposite wall. The opening should be made sufficiently far to secure perfect drainage.

J. N. MACKENZIE.

**BARATOUX.**—Hypertrophy of the Pharyngeal Tonsil. *Société de Méd. Pratique*, June 2, 1887.

*A propos* of some children whom the author had just treated, he insisted upon the arched form of the palatine arch, and the overlapping of the teeth, on the depression of the chest, and on the superior costal type of the respiration. The author treats the condition by scraping and tearing away the growths by the index finger. JOAL.

**LARRAND, T. H.**—Adenoid Tumours of the Naso-Pharynx. *Journ. des Sciences Méd. de Lille*, June, 1887.

THE author related an interesting case to the Medical Society of Lille, adding judicious observations on the symptomatology and treatment of the affection, remarking that the operation for post-nasal vegetations can be performed by all practitioners, and is not the exclusive property of specialists. He recommends especially the use of Loewenberg's forceps. JOAL.

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## LARYNX.

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**DESCROIZELLES.**—On a Form of Simple Laryngitis Difficult of Diagnosis. *Journal Lucas-Championnière*, July, 1887.

CATARRHAL phlegmasia of the larynx occurs sometimes in young children with exceptional physiognomy, giving it a resemblance to stridulous and diphtheritic laryngitis. As in the first of these two complaints, one observes raucous cough and attacks of suffocation, separated from one another by intervals of complete apyrexia, but which may be of sufficient intensity to excite serious alarm, although one finds no neoplasm in the pharynx. As in croup, there are fever and modifications of the *timbre* of the voice during the phases of calm which separate the spasms. One cannot too strongly call the attention of physicians to the observation of such cases, which seem, indeed, to be far from rare. JOAL.

**MACKENZIE, G. HUNTER.**—Treatment of Laryngeal Phthisis. *Brit. Med. Journ.*, August 27, 1887.

THIS may be medical, surgical, or climatic. Sedatives are preferable to caustics, especially morphine, iodoform, papayotin ( $\frac{1}{2}$ —5 per cent. solution), and cucaine, with its substitutes caffeine and menthol. The author refers to the use of lactic acid, as vaunted by Krause, Gleitsmann, Jellinek, &c., and does not report very favourably of its action. The author has not found sprays, inhalations, or insufflations of antiseptics (iodoform, corrosive sublimate, carbolic acid) of much service. The amenability of tuberculous lesions to treatment is in direct proportion to their accessibility. In the case of laryngeal tubercular disease, it is to surgery, intra or extra laryngeal, that we must look for successful treatment. The operation of tracheotomy, or laryngo-tracheotomy, is considered not only as a palliative, but as a directly curative agent. Two advantages are gained by opening the windpipe—rest and freedom from irritation of the larynx, and

direct access to the diseased areas for scraping, incision, or other process. In cases where the lung affection is quiescent, absent, or small in degree, and in which the laryngeal affection resists ordinary remedies, there should be no hesitation in resorting to surgical measures.

GREVILLE MACDONALD.

**CASTRO, OLIVEIRA.**—Treatment of Chronic Laryngitis. *Revista de Medicina Dosimetrica, February, 1887.*

THE author recommends for catarrhal laryngitis, helenine and sulphide of calcium; in specific laryngitis, iodoform and hydrargyrum; in tubercular forms, iodoform and arseniate of soda; in variolous forms, sulphide of calcium; in enteric forms, salicylate of ammonia. For the treatment of symptoms: Tannic acid for dysphonia; for cough and pain, hydrobromate of morphine; for dyspnoea, emetics and sulphate of strychnine; for suppuration, iodoform and arseniate of soda.

RAMON DE LA SOTA.

**PALACIOS.**—Laryngeal Syphilis. *Los Avisos, June 10, 1887.*

A MAN, thirty-six years of age, began to feel a tickling in the larynx, followed by pains and dyspnoea, increasing to such an extent that upon entry into the hospital he was attacked with orthopnoea and inability to swallow any solid food. With the laryngoscope there was observed a thin epiglottis, a hyperæmic laryngeal mucous membrane, œdematous vocal cords, at the anterior insertion of which was situated a large mucous tumour which almost occluded the whole lumen of the larynx. The vocal cords were very near together, the right one being in the cadaveric position, and having several growths upon its superior aspect; the left one was parietic, and possessed a semi-circular and extensive ulceration of the inner edge. Under the right vocal cord there was an extensive ulcer, and from under the left vocal cord sprang a good many outgrowths. The left arytenoid cartilage was reddish, and rounder than normal; the right arytenoid was five times larger than its natural size, and numerous points of suppuration were visible in both of them. From the antecedents of the patient, the character of the laryngeal lesions, the glandular swellings, and the presence of periostitis in both legs, the diagnosis of syphilitic laryngitis was made. Under treatment by iodide of potash and mercurial frictions, the patient (who was on the point of being tracheotomized) made a complete recovery, and not a trace of laryngeal mischief remained.

RAMON DE LA SOTA.

**MASUCCI, P.**—Contribution to the Etiology and Treatment of Acute Œdema of the Mucous Membrane of the Arytenoids. *Giorn. Internaz. di Sc. Med., 1887.*

A CASE of œdema of the arytenoids in an adult sixty-four years of age,

which developed quickly and was controlled speedily by the internal and external administration of ice. On the third day the patient was found to be without fever, notwithstanding that pyrexia was present at the commencement. The author thinks that the condition had a rheumatic origin, and thinks that in spite of the keen attention given to bacteriological processes in disease, the rheumatic diathesis is still an important factor in pathology.

MASSEI.

**THERMES.**—Two Cases of Laryngeal Vertigo in Whooping-Cough amongst Old People. *Journal de Méd.*, June 15, 1887.

BOTH cases occurred in old arthritic persons, and were treated and cured by large doses of bromide of potassium. Although the recent treatment of whooping-cough is all directed to antiseptic and antiparasitic medication, it would appear to result from these cases that there is still a place for sedatives; that, in the spasmodic period of whooping-cough bromide of potash, in large doses, possesses a remarkable sedative effect—a therapeutical effect long recognized and acted upon in France.

JOAL.

**WEGENER, G. F.**—Paralysis of Laryngeal Muscles as a Symptom of Tabes Dorsalis. *Dissertation, Berlin*, 1887.

THE author gives a bibliographical review of the subject, and relates two new cases of so-called "laryngeal crises" in tabes. These crises are fits of spastic cough, like whooping-cough, with dyspnoea, sometimes convulsions, and unconsciousness. As accompaniments of tabes they were first observed in France, and later by Kahler, and especially, Oppenheim. Afterwards, eight cases, with exact laryngoscopic examinations, were published by Weil, Krause, Landgraf, Krauss, and Knessner. All these cases present the same laryngoscopic appearances, viz., the permanent immobility of the vocal cords in the median line, or adduction. Such a constancy of results in all cases cannot be considered accidental, as Krause has asserted. The author insists upon the importance of laryngoscopic examination in central nervous affections. Therapeutically, potassic bromide and cocaine were of service.

H. KRAUSE (Michael).

**BESCHORNER** (Dresden).—Bilateral Paralysis of the Dilators of the Glottis caused by an Aneurism of the Aorta pressing on the Left Recurrent Nerve. Rupture of the Aneurism. Death. *Monatschr. für Ohrenheilkunde*, No. 5, 1887.

THE title describes the case.

MICHAEL.

**BANDLER.**—Idiopathic Abscess of the Larynx. *Präger Med. Wochenschrift*, No. 34, 1887.

ABSCESS of the larynx is a very rare disease. Thirteen cases are



published by Mackenzie, and nine others are collected by Ziemssen. The author has observed the following case :—A patient, thirty-seven years old, became ill without special cause, with fever, hoarseness, and stertorous respiration. With the finger could be felt, on the epiglottis, a tumour of the shape and size of a bean. The treatment consisted in external and internal application of ice. The following day the laryngoscope revealed a red tumour of the epiglottis with a yellowish coloured centre. The author made an incision, which was followed by the escape of a great deal of pus and great relief to the patient, who was completely cured in some days. MICHAEL.

**POLHERAT.**—Foreign Bodies in the Larynx. *Société Anatomique*, July 8, 1887.

THE author saw at the Hôpital Laennec an old woman, toothless, who, in gluttonously eating a piece of beefsteak, introduced it into the larynx, where it became fixed below the glottis. Attempts at extraction having failed, the patient died in eight minutes. In such a case ought one to perform tracheotomy?

Veretière in 1879 saved a case at the Bicêtre which was at the point of asphyxiation from the same reason. JOAL.

**EGIDI, F.**—Rapid Tracheotomy by the St. Germain Process. *Gaz. Med. di Roma*, April, 1887.

THE author relates a case of a boy, four years old, suffering from croup, and dying from suffocation, in whom there was scarcely time to operate even with the greatest rapidity. The author concludes from this case that the so-called "rapid process" may in some cases render the greatest service, and, therefore, modifies his views previously published in another place. MASSEI.

**D'URTO, G.**—Tracheotomy for Foreign Body. *Giorn. Internaz. delle Sc. Med.*, 1887.

AN old beggar, sixty-six years old, hastily eating a piece of meat, was suddenly taken with symptoms of dyspnoea, and applied to the Naples Hospital for Incurables. An examination with the finger yielded negative results as to the pharynx and larynx. Artificial respiration was resorted to and tracheotomy performed. (We cannot but deplore the absence at this important institution of a laryngoscope and a laryngoscopist. If a proper examination had been made by this method, no doubt the foreign body could have been extracted *per vias naturales* by the long forceps, without exposing the patient to the risks of tracheotomy, since the piece of meat was the same evening easily extracted by the forceps after the tracheotomy had been done.)

MASSEI.



**McNAUGHTON** (Brooklyn).—**Intubation.** *New York Medical Record*, June 4, 1887.

THE dangers of intubation in unpractised hands—which should be made familiar by performing the operation on the cadaver—are clearly shown. Holding the finger too long in the larynx, forcing the tube through one of the ventricles of the larynx, pushing the membrane down in front of the tube (never known to occur on the first introduction), and placing the tube in the œsophagus instead of the glottic chink, are some of the unpleasant occurrences to the unskilled operator. On the other hand, the advantages are, when properly performed :

1. The consent of the relatives and friends is obtained early, and without difficulty. 2. The operation takes but a few moments. 3. The air enters by the proper channel, and is less irritating. 4. The cough has more expulsive power for forcing the bronchial mucus through the tube than in tracheotomy. 5. Intubation does not preclude tracheotomy. Statistical table shows 71 recoveries out of 280 cases—over 25 per cent.

**WAXHAM, F. E.** (Chicago).—**Intubation of the Larynx, with Inferences from 134 Operations.** *Journ. of Am. Med. Assoc.*, July 30, 1887.

THE ages of Waxham's patients were as follows :—

5 cases with 1 recovery, or 20 per cent.				under 1 year.	
15	„	„	3 recoveries, „ 20 „ „	between 1 and 2 years.	
29	„	„	7 „ „ 24 „ „	2	„
23	„	„	4 „ „ 21 „ „	3	„
21	„	„	7 „ „ 33 „ „	4	„
15	„	„	7 „ „ 46 „ „	5	„
3	„	„	1 „ „ 33 „ „	6	„
9	„	„	2 „ „ 22 „ „	7	„
4	„	„	2 „ „ 50 „ „	8	„
2	„	„	2 „ „ 100 „ „	9	„
2	„	„	0 „ „ 0 „ „	11	„
1	„	„	0 „ „ 0 „ „	14	„
7	„	„	0 „ „ 0 „ „	—	„
<hr/>				<hr/>	
136		37'	27'20	Average age, 3 yrs 8 mns.	

Seventy-two cases were three years old or under, with sixteen recoveries, or 22 per cent. ; sixty-four were over three years, with twenty-one recoveries, or 32'8 per cent. The youngest to recover was nine months old, the oldest nine years. In every case false

membrane was present. The longest period the tube was worn was two weeks, the child being but two years old, and making a perfect recovery. The shortest period the tube was worn was one hour, in a desperate case, with recovery. Dr. Waxham has not performed the operation until surgery is imperatively demanded. Dr. Waxham's paper gave rise to a lengthy discussion which is fully reported in the *Journal*, and will repay perusal. J. N. MACKENZIE.

**MUDD, H. H.** (St. Louis).—**Tracheotomy and Intubation.** *Journ. of the Am. Med. Ass.*, June 25, 1887.

AFTER a lengthy critical discussion of the two methods, the author draws the following deductions:—Mechanical obstruction in the larynx demands relief when sufficiently great to threaten death. Tracheotomy, when performed under similar conditions with intubation, promises better result, because—

1. It does not interfere so much with deglutition and nutrition.
2. The opening can be maintained as long as desired.
3. The opening is larger, and is not so likely to become plugged with membrane.
4. If plugged, the tube can be removed by the most ignorant attendant.
5. It enables us to introduce moist, warm, pure air to the lungs.
6. It gives us a much better chance to clear and cleanse the trachea.
7. The operation is not more dangerous from hæmorrhage, from injury of important parts, from death from chloroform, narcosis, or from suffocation, than is intubation from the laceration of contiguous parts, from the escape of the tube into the stomach, or from suffocative attacks excited by manipulation, and by the detachment of membrane.

Intubation is, however, not to be condemned. It has its sphere of usefulness, and it may be said in its favour—

1. It is bloodless, and consent can be obtained when other operations would be denied.
2. It is more quickly performed, and is done without an anæsthetic.
3. It will relieve, ordinarily, the symptoms of dyspnoea.
4. It will probably find its chief benefit when applied to chronic obstructions of a cicatricial character. Its influence in acute cases will be pernicious, because it does not fulfil so well the necessities of the case, and will be resorted to by the unskilful and timid surgeon as an easy way out of a difficult position. J. N. MACKENZIE.

**WHEELER, J. B.** (Burlington, Vt.).—Intubation of the Larynx.  
*New York Med. Journ.*, February 26, 1887.

A GIRL of three and a half with membranous croup, cyanotic laboured respirations forty-eight to the minute, with dilated nostrils and recession of the ensiform cartilage, and pulse rate of 156, was intubated. In five minutes the respirations fell to thirty, and pulse rate to 120 a minute. Perfectly comfortable for twelve hours, the child then had a severe fit of coughing, and died suddenly. The tube was plugged with a large piece of false membrane, completely obstructing it. Skilled assistance was not at hand, or the result might have been different.

**COHEN, SOLIS.**—Description of a Modified Laryngectomy. *N. Y. Med. Journ.*, June 18, 1887.

THIS operation removes the entire respiratory portion of the larynx, leaving the greater portion of the protecting thyroid cartilages undisturbed to perform their function as shields, and it should fulfil every indication which has prompted entire laryngectomy, being applicable to the unilateral as well as to the bilateral procedure. The following are the steps of the operation, which can be performed within two minutes :—

1. Make an incision from the hyoid bone to the lower border of the cricoid cartilage, exactly in the middle line.
2. Carefully separate the sterno-hyoid muscles.
3. Hold the soft parts aside, and, inserting one blade of a strong cutting forceps with narrow blades from above, beneath one wing of the thyroid cartilage, one-fourth of an inch from the angle of junction with its fellow, sever the cartilage vertically its entire length through to the crico-thyroid membrane.
4. Make a similar cut on the opposite side.
5. Seize the freed angular portion of the thyroid cartilage, comprising its entire respiratory contingent, with vulsellum forceps, and draw it to either side, the soft parts being separated meanwhile from the inner surfaces of the detached wings of the thyroid cartilages with the handle of the scalpel.
6. Make a transverse cut to sever the cricoid cartilage from the trachea. A sterilized cotton plug should be inserted into the upper end of the trachea, preliminary tracheotomy having been previously performed.

7. Lift the cricoid cartilage forward, and carefully separate it with the edge of the knife from the inferior cornua of the thyroid, laterally and superiorly, and then from the œsophagus posteriorly.
8. Insert a finger into the pharynx from below, and carry its tip over the epiglottis to draw that structure down.
9. Divide the thyro-hyoid membrane and the fibrous tissues still holding.
10. Lift out the excised respiratory portion of the larynx.

The arteries requiring ligature will comprise small branches of the superior, middle, and inferior laryngeals. The advantages alleged for this procedure are :

1. Rapidity, ease, and comparative safety to the patient.
2. The small size of the wound.
3. The preservation of the attachments of the thyro-hyoid ligament, and the greater part of the membrane, and of the thyro-hyoid, sterno-thyroid, stylo-pharyngeus, and inferior constrictor muscles ; leaving important functional structures retained in their normal relations of deglutition, and a firm natural support for the adjustment of artificial substitutes for the larynx. The operation is applicable in all cases where the thyroid cartilage is not involved.

**KÜSSNER (Halle).—On the Physiological Process of Ventriloquy.**

*Deutsch. Med. Wochenschr.*, No. 31, 1887.

By intonation whilst the glottis is very tightly closed with blowing only by use of the thoracic walls without the help of the abdomen (which must remain immobile), the singular timbre of the ventriloquist can be produced ; but there are also some other factors, viz., the elongation of the mouth by depression of the larynx helps to change the timbre of the voice, which now seems to come from the deeper regions, and the tone becomes more peculiar still by the applied head voice. By reason of the mouth remaining closed in speaking the voice is less distinct, and gives the impression that it comes from a distant place.

MICHAEL.

## NECK, &c.

**GRUZNER (Tubingen).—Physiology of the Thyroid Gland.**

*Deutsch. Med. Wochenschr.*, No. 32, 1887.

THE author concludes that cachexia strumipriva is caused by a toxic substance which circulates in the blood, and which normally is

destroyed by the action of the cells of the thyroid gland. The toxic substance is, as Horsley maintains, mucin. MICHAEL.

**DITWICH** (Prag).—**Large Intra-thoracic Tumour caused by Cystic Degeneration of a Goître.** *Präger Med. Wochenschr.*, No. 31, 1887.

A PATIENT, sixty years old, with a large intra-thoracic tumour, diagnosed as a fibroma, died, and the author made the autopsy. As the thorax was opened a tumour was seen of the circumference of a man's head. A small part of the tumour was of goitrous tissue; but much the greater part was a cyst containing about three litres of a thick brown-yellow fluid. This is the largest intra-thoracic tumour which has ever been observed. MICHAEL.

**CALDWELL, CHARLES** (Chicago).—**Enlarged Thyroid, or Goître, a Cause of Transverse Presentations.** *Maryland Med. Journal*, July 23, 1887.

THE patient had been confined ten times, the first seven being normal deliveries; the last three, transverse presentations, had complicated the case. Seven years before, the left lobe of the thyroid gland began to enlarge during gestation, but caused neither pain nor dyspnoea. Four years later, during her eighth pregnancy, the right lobe began to enlarge, and increased in size very rapidly, producing both pain and dyspnoea, compelling her to take a semi-recumbent position at night instead of a horizontal one. During the last three months of gestation she sat bolstered up in bed at night. This position, which she was obliged to take whenever she sat down during the day as well as the night, produced continued pressure on the fundus of the uterus, changing its long axis from vertical to the oblique or transverse direction. Of course, the long axis of the foetus must coincide with that of the uterus, and the continued pressure on the breech or head, according to the end of the foetal ovoid at the fundus, would force it into an oblique or transverse position, and also throw the lower end of the foetus out of the pelvis and above its brim. The same position of the mother is maintained during labour as during the last three months of pregnancy; hence the foetus remains in the same oblique or transverse position, and the lower end of the foetal ovoid cannot descend below the pelvic brim. J. N. MACKENZIE.

**FUHR.**—**Cachexia Strumipriva.** *Münchener Med. Wochenschr.*, 1887, No. 26, 27.

A REVIEW of the latest papers published on this subject.

MICHAEL.



## ASSOCIATION AND CONGRESS MEETINGS.

### The British Medical Association.

*55th Annual Meeting, held at Dublin August 2, 3, 4, and 5, 1887.*

REPORT OF THE SUBSECTION OF LARYNGOLOGY AND RHINOLOGY.

*Chairman, Dr. W. MACNEIL WHISTLER.*

IN opening the proceedings of the Subsection, the Chairman delivered a short address, in which he lamented the fact that this country was still unrepresented by any special association devoted to the interests of laryngology and rhinology, and expressed the hope that such an association might shortly be formed.

*Laryngeal Phthisis.*—A discussion on this subject was opened by Dr. PROSSER JAMES, who put the following questions to the members of the Subsection for inquiry. 1. What is laryngeal phthisis? 2. Is there such a disease as laryngeal phthisis? 3. What is the relation of bacilli to laryngeal phthisis? 4. Can cases of laryngeal phthisis recover? 5. What is the proper treatment of laryngeal phthisis? Two points require special attention, viz., the influence and power of antiseptics and manipulative interference. The speaker referred to the treatment by sulphurous acid gas inhalations, to surgical proposals to scrape the ulcers in the larynx and inject lactic acid and iodoform (Gougenheim), to injections of acid phosphate of lime (Kolischer), and to Moritz Schmidt's method of making deep incisions, and condemned this "recrudescence towards surgical measures."

Mr. LENNOX BROWNE recognized the bacillary origin of the tuberculous process, and maintained that the larynx might be infected by inoculations of the sputa, or more usually through the systemic circulation, and the parts first affected were those physiologically liable to early effects of anemia, namely, the marginal and apical regions. When the exciting cause was functional abuse, the parts affected first would be the vocal cords and ventricular bands. When the fauces and pharynx were later on affected bacilli were here deposited, not necessarily on any breach of the surface, but because these parts, weakened by contamination of oral and other fluids, were receptive of organisms conveyed through the general circulation. Phthisis of the larynx was admitted now to be sometimes primary.

The treatment should be: 1. To place the patient in a resistant position towards bacilli. The means to this end were climatic, hygienic, and inhalation treatment. Oro-nasal appliances conveying vapours by alcohol or ether are preferable; steam inhalations are to be deprecated. 2. To annihilate the bacillus by germicides. Corrosive sublimate, aniline, and rectal injections of  $\text{H}_2\text{S}$  and  $\text{CO}_2$ . A case was related in which the self-administration of Bergeon's treatment may have been held to precipitate a fatal result. Of local germicides, preference was given to galvano-cautery for healing ulceration of the larynx and tonsil; lactic acid and scraping for tubercle of the fauces; and menthol to the larynx over iodoform or iodol. Morphine insufflations are purely palliative. 3. Surgical measures were all condemned, even ablation of the uvula in a tuberculous subject. He also condemned Massei's suggestion for extirpation of the tuberculous larynx.

Dr. HUNTER MACKENZIE read a paper on the "Treatment of Laryngeal Phthisis" (abstracted at p. 343).

Dr. WOAKES stated that he had used sulphuretted hydrogen for the last seven or eight years, both in private and hospital practice, in the form of sulphide of

calcium in hot water as an inhalation, with great benefit. He spoke of the relief afforded by tracheotomy.

Mr. STOKER preferred sprays, and thought starch powders tended to become pasty.

Dr. F. H. HOOPER (Boston, U.S.A.) subscribed to Mr. Lennox Browne's views. He had never seen a case of tuberculous ulceration of the larynx recover under any treatment. He relied on general hygienic and dietetic measures, and spoke favourably of sprays of 10 to 20 per cent. cocaine for painful deglutition.

Dr. WARDEN treated his cases with eucalyptus, atropine, and terebine, and used lactic acid, thymol, menthol, cocaine, iodol, and iodoform locally. Intubation, extirpation, scarification, and useless activity were all condemned. Laryngeal tubercle might exist as a separate disease, and might even recover.

Dr. R. A. HAYES said tuberculosis of the larynx was sometimes primary—an observed case suggested the possibility of its cure. Insufflations of powders were probably almost worthless. Sprays, astringent and sedative, should be employed. Arsenic had given him good results.

Dr. WHISTLER thought that tuberculosis of the larynx was sometimes primary; never acute laryngeal tuberculosis, but cases in which chronic laryngeal inflammation, leading to slow progressive change with ulceration, occurred as precursors of pulmonary phthisis. Such cases were perhaps curable if treated sufficiently early. Such cases resembled a form of tertiary syphilis of the larynx which he had called "chronic syphilitic fibroid of the larynx."

*On Tuberculosis of the Tonsils.*—A paper was read by W. LUBLINSKI on this subject (abstracted at p. 334).

*On Distension of the Nasal Arch (Transverse Nasal Vein) in Children; its Pathology and Treatment.*—This paper was read by Dr. W. H. SCANES SPICER, and is abstracted at p. 342.

*Discussion on Reflex Neuroses of the Naso-Pharynx.*—Dr. WOAKES introduced this subject, claiming to have added to the list of already established neuroses paresis of the palate, parietic dysphagia, and hypochondriasis. All these phenomena are to be explained by reflex dilatation of the nutrient vessels of certain nerves producing motor paralysis, or if of a sensory nerve, neuralgia. Epileptiform attacks had followed the application of caustics to the turbinated bodies.

Mr. GEORGE STOKER related two cases of periodic sneezing relieved by the use of the galvano-cautery.

Mr. LENNOX BROWNE related two cases of epileptiform seizures due to reflex from the nose, and cured by local measures.

*Laryngeal Stenosis.*—Mr. LENNOX BROWNE exhibited a new hollow laryngeal dilator with cutting blade devised by him. It combined the advantages of Whistler's cutting dilator with Schrötter's hollow tube.

*Nasal Instruments.*—Mr. LENNOX BROWNE exhibited Holbrook Curtis's improved saws, trephine, and electro motor.

*A New Aid to Tracheotomy.*—Mr. STOKER exhibited a barbed needle fixed on a handle to plunge into the trachea, with the object of drawing it forward before the skin incision is made.  
GREVILLE MACDONALD.

## REPORTS OF SOCIETIES.

### Spanish Medical and Surgical Academy.

*March 7, 1887.*

*Diphtheria.*—Dr. ROBERT is of opinion that diphtheria is an infectious, febrile, and eminently contagious disease, which determines more or less extensive local lesions, principally in the fauces, consequent upon the general condition. He distinguishes a mild and a severe form, and, comparing its evolution with the exanthemata, he admits as in these, a period of evolution, in which the disease is developed, uninfluenced by medicines. He believes that there are several points of infection, and, speaking of micro-biological researches, concludes that they are little reliable, and contradictory, and that it is impossible to declare what is the micro-organism of diphtheria. The local treatment is quite secondary, and it sometimes produces erosions which increase the extent of the lesion; but, avoiding irritant and caustic procedure, he employs local treatment in order to cleanse the diseased surface, and destroy infective matters and prevent gangrenous processes. He recommends boracic solutions, volatile oil of turpentine, and lemon-juice. As there is difficulty or impossibility of deglutition, nutrition fails, and the gravity of the disease is intensified. In order to prevent this, it is necessary to administer fluid nourishment. Since the fever is not intense, antipyretics are unnecessary, but tonics, wine, and Peruvian bark are required. With regard to so-called anti-diphtheritic medication, he speaks favourably of sublimed sulphur and sulphurous waters, sulphide of calcium, and cubebs, and believes that pilocarpine is a powerful agent in relation to the general affection and as a preventive of membrane-formation, but dreads its use, by reason of the facility with which the drug induces collapse. Diphtheria, at the present time, is badly in need of a rational therapeutics.

RAMON DE LA SOTA.

### Berlin Medical Society.

*Meeting, July 27, 1887.*

*On Pachydermia Laryngis.*—R. VIRCHOW.

The researches of Virchow and Rainer had shown that there is a certain analogy between the mucous membrane of the larynx and the skin, and there are therefore diseases of this region which have great similarity to diseases of the skin. Two processes must be differentiated, one of them affects the mucous tissues mostly; the other, the epithelium, and renders it similar to a thin skin. Both diseases are chronic inflammatory processes. The latter is called by Virchow, *pachydermia*. There are two kinds of pachydermia, the *diffusa* and the *verrucosa*. The parts most liable to diffuse swellings are those where there is not so much connective tissue, especially the processus vocales of the arytaenoid cartilages. Here frequently occur swelling and epidermic hypertrophies which may be looked upon as cancerous. It is not right to call such neoplasms "papillomata"; they must be called epitheliomata, and a distinction must be made between *hyperplastic* and *heteroplasic* epitheliomata. The microscopical difference between these forms is often difficult, and is dependent on the nature of the basis of the neoplasm. If in the basis is epithelium, especially of alveolar structure, there is a carcinoma; but if the basis is of normal structure, the neoplasm is benign, and the same if the surface is covered with papillae. Such papillary growths are found not only on the vocal bands, but also in the interarytaenoidal space, the epiglottis, and also on the pharynx and uvula. Such growths must not be viewed as fibromata. Virchow illustrated his lecture with specimens and sketches. Such growths can easily

recur, but it must be allowed that by energetic treatment they can be finally perfectly destroyed. They can also disappear as spontaneously as cutaneous warts will do.

WALDEYER could positively state that wherever there is pavement epithelium, there are also papillæ, and he does not believe that the epithelial growths occur without papillary growths also.

VIRCHOW stated that in his case he had not seen papillæ.

WALDEYER maintained that very much depended on the direction of the cut. If it is parallel to the vocal bands, it can easily be between the papillæ; but if it is a cross direction they are always seen.

LEWIN agreed that he always found pavement epithelium combined with papillæ.

MICHAEL.

### Hamburg Society of Physicians.

*Meeting, May 17, 1887.*

E. FRÄNKEL showed an œsophagus with phlebectasies in a patient who died the evening before of hæmorrhage. There were cirrhosis hepatis and diffuse dilatation of the blood-vessels of the lower part of the œsophagus.

*On the Connection between Diseases of the Nose and the Lungs.*—THOST had found the coccus of pneumonia (Friedlander) in different diseases of the nose, especially in ozæna. He could produce pleuro-pneumonia with his coccus in rabbits, and found the coccus in the exudations of the pleura. He could make cultures of the secretion of ozæna, of chronic rhinitis, and of coryza. He believed that in pneumonia the lungs were infected from the nose. In the treatment of acute coryza he recommended a combination of salicylic acid and sodium bicarbonate. He rejected entirely the use of cocaine.

MICHAEL.

### Royal Society of Physicians in Buda-Pesth.

*Meeting, March 21, 1887.*

NAVRATIL showed two cases of laryngeal stenosis. In the first case there were attacks of suffocation, which rendered tracheotomy necessary. The cause was perichondritis of the cricoid cartilage, followed by ankylosis of the crico-arytænoid articulation. It was cured by local treatment. In such cases tracheotomy must always (but never laryngotomy) be performed, because the canula in an inflamed larynx is a cause of chronic processes. He showed a second case in which the operation was made on the larynx, and was followed by a chronic sclerotic inflammation which could not be cured by intubation. He will endeavour to cure the case by resection of the larynx.

MICHAEL.

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## REVIEWS.

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### CORRAL Y MAIRÁ.—Medical Study of Diphtheria and its Effective Treatment.<sup>1</sup>

THIS pamphlet comprises seven chapters. The first treats of the history and bibliography of diphtheria; the second deals with the genesis and etiology, in which the author considers the disease as a specific one, local at first, becoming general afterwards, and produced by a microbe, which, however, is still unknown. The third chapter

<sup>1</sup> *Estudio Médico de la Difteria y su Tratamiento más Eficaz.* Madrid, 1887.



deals with pathological anatomy, under which head the false membranes and the pathological changes in the blood and urine are discussed. The fourth and fifth chapters are devoted to symptomatology; the sixth deals with diagnosis and prognosis; and the seventh with therapeutics. The author recommends that energetic local treatment should be avoided, and disinfection, oxalic acid, and sufficiently nutritious diet be the means relied on. RAMON DE LA SOTA.

**HADDON.—Notes from Private Practice: I. On Sore Throat.<sup>1</sup>**

THE author is evidently a very observant general practitioner. If all who are engaged in this department of practice would record their experiences in the same manner, much help would be given to those engaged in special study. The relations of the "sore throat" to infectious diseases generally, and what—to borrow a natural history expression—we may term "the life history" of such conditions, are of great importance, and no one can study these conditions so well as the general practitioner. The section relating to "Infectious Sore Throat" is much the most interesting. Under this head the author includes several varieties, and thinks they depend upon different causes, or the same cause under different conditions. Insanitation, certain meteorological states favour their origin and spread, and infected milk is a potent propagator. He relates cases of hospital sore throat, diphtheria, and scarlatinal sore throat, and expresses the opinion that cases of so-called croup met with in boys up to about six years of age are conditions resulting from a chill, and accompanied with bronchial mischief and some change in the larynx. Such cases during an epidemic of diphtheria may, however, be slight cases of laryngeal diphtheria, and should be carefully watched. The author regards tracheotomy in laryngeal diphtheria as distinctly discouraging, usually forbidden in general practice and often undertaken as a last resort, and suggests intubation. Several interesting cases are related by the author. The pamphlet will repay perusal.

R. N. W.

<sup>1</sup> Reprinted from the *Provincial Medical Journal*, May and June, 1887.

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## NOTES.

**Honours for Laryngology.** Laryngologists will be pleased to learn that Her Majesty the Queen has signified her intention of conferring the dignity of knighthood upon Dr. Morell Mackenzie in recognition of his services in the treatment of H.I.H. the Crown Prince of Germany.

**The British Medical Association Meeting.** This year, for the first time, laryngology was awarded a prominent place at the Dublin meeting. The section does not appear to have been very successful, either as regards the number of laryngologists present or the results of the meeting. It is to be hoped that at the



next meeting greater results will be forthcoming. The suggestion of the Chairman that a Laryngological Association should be formed in this country is worthy of consideration. The idea has, however, occupied the minds of others besides Dr. Whistler. Difficulties have stood in the way of its accomplishment, which time may perhaps remove. Before laryngology can obtain the position in this country which it is entitled to, the science must present a more solid front than it can at present show.

**Double Uvula.** From an old number of the *London Medical Gazette* (Vol I. 1840-41), long since extinct, we extract the following remarks by GEORGE BOLSTER, *Surgeon*:—"On November 2, I was called to see Mary O'Donnell, a peasant girl, aged eight years. She had an infection of the glands of the neck. . . . Having had occasion to inspect her throat, I perceived two *uvulas* projecting from the palate, perfectly distinct and of equal size, of which circumstance the parents of the child were seemingly ignorant. She had never complained of inconvenience attending it. Her voice is clear and strong, and, strange to say, she can with great ease, extend it to *three octaves*. . . . I have never seen a case similar to this, but have seen two cases with total absence of the uvula; one in the person of a Hindoo girl at Calcutta in 1836; and since then in a patient of Mr. Wallace, surgeon, of Bow. In both cases the voice was perfectly natural."

To ensure the early insertion of abstracts, Authors are requested to *send a copy of any journal* which may contain a contribution on disease of the throat or nose, or on cognate affections, to the EDITORS, *Journal of Laryngology*, 11, New Burlington Street, London.

Afin de s'assurer une prompte insertion de leurs extraits, les auteurs sont priés d'envoyer un numéro de tout journal contenant un article quelconque sur les maladies de la gorge ou du nez et sur les affections qui y ont rapport, aux REDACTEURS du *Journal of Laryngology*, 11, New Burlington Street, London.

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THE  
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No. 10.

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A REPORT UPON LEPROSY  
IN EUROPE (PARTICULARLY AS IT  
AFFECTS THE AIR-PASSAGES).

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HAVING within the last few years had opportunities of studying leprosy in Spain, Madeira, and Norway, it has occurred to me that an account of my observations may be of interest to some of my professional brethren. My attention was mainly directed to the manifestations of the disease within the throat—a field of observation which has not as yet been exhaustively worked out. Not that it is by any means virgin soil; several competent inquirers have been before me, and I can scarcely hope to add much of any value to the observations of Moura-Bourouillon, Schrötter, Stoerk, and Elsberg. Still, in a disease respecting which so little is even now really known, it is something to have results arrived at by previous workers decisively confirmed, and gathered once for all into the general stock of established scientific truths. My observations, whatever they may otherwise be worth, have at least this merit, that they are based on a larger and more varied clinical material than any of my predecessors has had to deal with. Scrupulously accurate as far as they go, they must not, however, be taken as affording a complete picture of the course of leprosy within the throat. This would require a long period of time, possibly many years, to execute satisfactorily, as each case would have to be kept under continuous observation from the onset to the termination of the malady. So far as I know this still remains to be done; it could, of course, only be carried out by a physician resident in some place where leprosy is endemic. Chances of studying the disease in the living subject are fortunately rare in the countries where laryngology is most cultivated, whilst in places where leprosy has its customary *habitat*, systematic examination of patients' throats during life seems to be somewhat neglected. This is, no doubt, to be accounted for by the altogether secondary importance of the throat affection, which makes the practitioner quite independent of

the laryngoscope as far as diagnosis is concerned. It is conceivable, however, that in localities where, owing to the extreme rarity of the complaint, the medical man has not that intuitive—one might almost call it instinctive—power of recognizing leprosy which is common even among the laity in countries where the disorder is indigenous,<sup>1</sup> inspection of the throat might be of use. I hope, at any rate, to show, as the result of my own observations, that whilst the throat symptoms are not in all cases absolutely distinctive, they yet often present sufficiently characteristic features to enable an expert to determine their nature without much hesitation. It may, of course, be said that this is rather an academical subtlety than a matter of practical importance, as leprosy always attacks the outer parts of the body before it invades the throat. Cases, however, might possibly occur—in this country at least—in which the skin affection alone would be obscure or even misleading to an observer unfamiliar with leprosy. Under such circumstances the condition of the throat might throw light on the nature of the disease. In the Middle Ages, when every one with a husky voice was looked on with suspicion as being either actually a leper, or, at any rate, *in dispositione leprae*,<sup>2</sup> such a means of diagnosis would have been of inestimable service. The little mirror would have saved many a hapless wight who, like Falstaff, had lost his voice “with hallooing and singing of anthems,” from being cast forth from among his fellows, and condemned to the living death which was then the leper’s doom.<sup>3</sup>

Even at the present day it is not altogether impossible that the laryngoscope may be found useful for a like purpose. The dread of leprous contamination is once more becoming a factor in human action in some parts of the world,<sup>4</sup> and alarmist cries have lately

<sup>1</sup> See Vandyke Carter: *Reports on Leprosy in North Italy, the Greek Archipelago, Palestine, &c.* (Second Series), London, 1876, p. 7.

<sup>2</sup> See Joh. Matt. de Gardli: “Consilia Venet,” Cons. 99—*Pro illustri Alamanno ad Leporam Disposito*, in which the “*vox notabiliter rauca*” formed a most suspicious symptom. Happily, the “illustrious German’s” voice, “*facta est sinit sana*,” and all his fears as to his condition were dispelled.

<sup>3</sup> See the late Sir James Simpson’s most interesting “Antiquarian Notes on Leprosy” in the *Edinburgh Medical and Surgical Journal*, 1841-42; and an article by Agnes Lambert on “Leprosy Past and Present,” in the *Nineteenth Century*, September, 1884, particularly p. 482, *et seq.*

<sup>4</sup> See in the *Boston Medical and Surgical Journal*, May 15, 1884, the report of a legal action for libel brought by a physician, a member of the Board of Health in Honolulu, against a local journal which had accused him of “criminal mismanagement of leprosy.” The “mismanagement” consisted in the discharge of patients from the “leper settlement” whilst still suffering from active forms of the disease. The jury returned a verdict of not guilty. It may be added that, from occasional paragraphs in the American medical journals, it is clear that the possible importa-



been heard within our own "tight little island" itself.<sup>1</sup> Under these circumstances, rules as stringent as the Draconian code of mediæval Europe may again be enacted, dooming the leper to a "segregation," which practically amounts to civil death. In coming to a decision upon a matter so vitally affecting the happiness of the individual, the physician must be careful not to overlook any feature of the case that may, in however slight a degree, help him to a correct conclusion. For this reason, if for no other, it is of the utmost importance that the phenomena of leprosy as exhibited in the throat should be minutely studied, and as far as possible differentiated from the other lesions that may occur in that part. The present essay embodying, as I believe it does, everything of value that has hitherto been recorded by competent observers, will, it is hoped, be of use in giving the reader a clear and adequate notion of the effects of leprosy on the air-passages.

The alteration of the voice in leprosy has always been considered as one of its most marked features, and not one of the older writers omits to mention it. It was variously described as "hoarse," "nasal," "rough," "shrill," "yelping" (*catullina*) and, as being in due course altogether lost. Even to the laity this was one of the most striking signs of the disease; thus Creseide in Hennyson's Lament, says:—

My clere voce and my courtly carolling  
Is ranke as roke, full hidous, har and hace.<sup>2</sup>

and FitzHerbert in commenting on the writ, *De leproso amovendo*, says: "It seemeth that the writ is for those lepers who appear to the sight of all men that they are lepers by their voice, and their sores, &c."<sup>3</sup>

Among the "signo infallibilia" of the disease, B. Gordon enumerates<sup>4</sup> the following "coarctatio (narium) internis cum difficultate anhelitûs, ac si cum naribus loquantur," and among the symptoms of *incipient* leprosy, he says that one is "vox aliquo modo rauescit," becoming, as the *naufragium* or end of the malady of leprosy, either from the Sandwich Islands or from China (*vid* San Francisco), was even recently a subject of apprehension in the United States. See, for instance, a case reported in the *Philadelphia Medical News*, 1882, p. 727, in which a patient at Salem, Massachusetts (who had lived at Honolulu in the capacity of chief botanist to Queen Emma), was declared to be suffering from leprosy, whereupon he was isolated, and his clothes were burnt.

<sup>1</sup> Agnes Lambert: "Leprosy, Present and Past," in the *Nineteenth Century*, August, 1884, p. 210, *et seq.*

<sup>2</sup> Sibbald's *Chronicles of Scottish Poetry*, vol. i. p. 117. Edinburgh, 1802.

<sup>3</sup> *The New Natura Brevium of the Most Rev. Judge Mr. Anthony FitzHerbert*, eighth edition. In the Savoy, 1755, p. 534.

<sup>4</sup> *Lilium Medicinæ*. Francofurti, 1617, p. 108.



approaches, "rauciloqua catullina," which he explains rightly enough according to his lights by the supposition of a "materia melancholica corrupta," which is deposited in the parts and thickens them (Grossat). Gilbert,<sup>1</sup> the Englishman, also speaks of "vocis gracilitas et mira asperitas quasi calutorium." Rhazes<sup>2</sup> places hoarseness among the earliest signs, and Haly Abbas<sup>3</sup> reckons it apparently as among the prodromata of the disease, for in some curious directions on the choice of slaves, the intending purchaser is warned against selecting any whose voice is hoarse. Hoarseness, frequent sneezing, and shortness of breath were also reckoned by Avicenna<sup>4</sup> among the early symptoms of leprosy. Averroes considered "raucedo vocis" as a "signum prognosticum." John Damascene,<sup>5</sup> on the other hand, mentions the affection of the voice as occurring in the progress of the disease, and as gradually increasing till it is complete. Aphonia ensues. Theodoricus<sup>6</sup> and Lanfrancus<sup>7</sup> agree substantially with him on this point. More modern writers are equally unanimous as regards the change in the voice, whether basing their description on cases seen in Europe, Africa, Asia, or America.

As already stated, my own observations were made in Spain (Seville), Madeira (Funchal), and Norway (Molde and Bergen). I visited the Hospital de San Lazaro, in Seville, in the spring of 1880. The building is outside the city, in a fairly isolated situation, and is well adapted for the purpose it is meant to serve. It is not solely destined for the reception of "lepers" in the strict sense, for patients suffering from true elephantiasis (Arabum), and some other forms of disfiguring disease, are also admitted.<sup>8</sup> During the year preceding my visit (1879) there had been 55 patients—40 men and 15 women—under treatment in the institution; of these, 9 men and 2 women

<sup>1</sup> *Gilberti Anglici Compend: Medicina*, Lugduni, 1510, lib. viii., De Lepra.

<sup>2</sup> *Ad Regem Mensorem*, lib. v., c. xxxv.

<sup>3</sup> "*Theoic*," Lugd., 1525, lib. i., cap. 24. "Rania enim (vox) elephantiam quandoque significat venturam."

<sup>4</sup> Canon: Lib. iv., Fen. iii., p. iii., c. ii. Venetiis, 1555.

<sup>5</sup> *Therap. Method.*, lib. ii., c. xv. Basil, 1545.

<sup>6</sup> "*Chirurgia*," c. 55, in *Artis Chirurg. Scriptior: Collect.* Venetiis, 1546, p. 173, et seq.

<sup>7</sup> *Art. Complet Chirurg.*, cap. vii. *Ibid.*, p. 207.

<sup>8</sup> *Memoria que dirijé a la Exma. Diputación Provincial de Sevilla el Decano del Cuerpo Facultativo de Beneficencia.* Sevilla, 1880, p. 32. It is there stated that persons of both sexes are admitted "que padecen las enfermedades leprosas, la elephantiasis en sus dos formas, de los Griegos y de los Arabes, y otros estados caquéticos acompañados de ulceraciones estensas é inveteradas que dan un aspecto repugnante a los desgraciados que las sufren." In 1879 I find there were two cases of cancer, two of elephantiasis, two of lepra vulgaris, and one of syphilis (Sifilis inveterada).

died, giving a rate of mortality of 20 per cent. In the five years from 1875 to 1880, there had been 101 patients in the hospital, of whom 17 were there at the first time of reckoning, whilst 42 remained at the end of the period; 18 had left for various reasons, whilst 41 had died, the death-rate thus being 40 per cent.<sup>1</sup> It was with considerable difficulty that I succeeded in obtaining admission to this institution—whether the unwillingness of the authorities was founded on ultra-humanitarian tenderness for the feelings of the unfortunate inmates, or on mere orthodox objections to the presence of an “hereje” within the walls.

Thanks, however, to the courtesy of the chief physician, Dr. Pedro Fuertes, I was enabled to view the hospital, and examine such of the cases as I thought might be interesting. At the time of my visit there were 29 male and 10 female patients. Of the former 9, and of the latter 2, had well-marked throat-symptoms. The following table shows the duration of the throat-affection as compared with that of the general disease.

MALES.

	Age.	Duration of Disease.	Duration of Throat Affection.	Remarks.
1.	34	5 years.	2 years.	Ulcers over whole of pharynx. Uvula destroyed; sides of throat acutely inflamed.
2.	35	8 years.	5 years.	Epiglottis so much enlarged that laryngoscopic examination was almost impossible.
3.	47	8 years.	6 years.	Ulceration of uvula. Enlargement and ulceration of epiglottis. Ulceration of left ary-tæmoid.
4.	28	13 years.	2 years.	General thickening of orifice of larynx. Uvula enormously thickened and elongated.
5.	33	9 years.	7 months.	Large ulcer in pharynx. Epiglottis enormously enlarged.
6.	31	?	2 years.	Ulcers over whole of pharynx and pillars of fauces. Uvula destroyed. Tubercles on tongue. Dysphagia.
7.	22	10 years.	10 years.	Uvula destroyed. Ulcers extending upwards from it symmetrically. Epiglottis enlarged.
8.	47	14 years.	10 years.	Uvula destroyed. Pharynx ulcerated on both sides. Epiglottis destroyed.
9.	16	10 years.	6 months.	Uvula and epiglottis thickened.

<sup>1</sup> Hauser : *Estudios medico-sociales de Sevilla.* Madrid, 1884, p. 319.

## FEMALES.

	Age.	Duration of Disease.	Duration of Throat Affection.	Remarks.
1	50?	12 years.	?	Epiglottis greatly thickened.
2.	26	9 years.	2 years.	

All these were cases of tubercular leprosy; the duration of the throat-symptoms is reckoned from the time when hoarseness was first observed. It is to be noted that whilst, as a rule, the voice became affected some years (2 to 11) after the invasion of the disease, in one case the throat was affected from the beginning. From a glance at these tables it will be seen that one constant feature of leprosy within the throat is enlargement of the epiglottis; this in some cases reaches an enormous degree, so as to completely hide the larynx from view. In one case of long-standing disease (ten years) the epiglottis was entirely destroyed, but this is quite exceptional; in one or two there were ulcers on it, usually at the edge and towards the side. Thickening of the arytenoid cartilages was almost universal. The uvula in four cases was entirely eaten away, in one partially destroyed, whilst in three it was thickened and enlarged—in one case in a very marked degree. The pharynx was extensively ulcerated in five cases; in one instance tubercles were observed on the tongue. In all the cases the whole upper orifice (arytenoids, interarytenoid fold, and ventricular bands, with the epiglottis) of the larynx was thickened so as greatly to narrow the aperture; this was particularly the case in a man aged twenty-eight whose uvula has been already mentioned as immensely hypertrophied.

I visited Madeira in the spring of the following year (1881), and examined several patients in the Lazaretto at Funchal. The building is situated on a cliff at the western extremity of the town; the inmates are comfortably housed, and their diet, without being on a luxurious scale, is relatively ample and sufficiently varied. They have flesh meat twice, and imported American cod-fish three times a week, with abundance of fresh vegetables, yams, cabbage, and sweet potatoes. I was informed that there were not so many patients in the hospital as formerly, because lepers were no longer compelled to enter. I give the results of my inspection in tabular form as before.

MALES.

	Age.	Duration of Illness.	Duration of Throat Ailment.	Remarks.
1.	19	9 years.	1 year.	Ulceration of vocal cords. General thickening of epiglottis and arytaenoid, especially left.
2.	28	14 years.	Recent hoarseness.	Do. as above. One brother a leper. Father and mother and rest sound.
3.	17	10 years.	?	Do., voice little affected.
4.	24	6 years.	?	Epiglottis thickened. Heredity remarkable. Two brothers affected and one half-sister; four brothers had died of the disease. Almost a vegetarian.

FEMALES.

	Age.	Duration of Malady.	Duration of Throat Ailment.	Remarks.
1.	22	9 years.	3 years.	Uvula destroyed. Epiglottis and arytaenoid thickened)
2.	30	9 years.	?	Vegetable diet; no fish.
3.	35	25 years.	Many years	Dyspnœa and cough. Father and one brother lepers; mother and others sound. Great thickening of inter-aryt. fold. Slight thickening of epiglottis.
4.	12	3 years.	?	General leprosy very slight. Voice nasal. Half-sister of No. 4 (males).

The general features in these cases (all examples of tubercular leprosy) are, it will be noticed, almost identical with those observed in the "lazarinos" of Seville.

M. M.

(To be continued.)

## DIPHTHERIA.\*

**WEBER.**—Report of 200 Cases of Diphtheria in the Children's Department of the Charité Hospital in Berlin. *Inaugural dissertation, Berlin.*

CASUISTIC review.

MICHAEL.

**THOINOT.**—Contribution to the Etiology of Diphtheria. *Soc. de Médecine Publique, July 27, 1887.*

A PERSON quitting a diphtheritic circle may, without being ill himself

\* As this number contains a full account of the proceedings of the American Laryngological Association, many abstracts are unavoidably held over from this and other sections.

transport the disease to some spot where it may become established. How is this transport effected? Without doubt by the linen clothing which is infected at the epidemic centre, and in which the germ is preserved. The following fact is the proof of it: A patient in Algeria died of diphtheria. The linen and effects were sent to Laval to the patient's brother. The latter fell ill with diphtheria and died in three days. JOAL.

**ZIEMSEN.**—On Diphtheritic Paralyses and their Treatment. (*Klinische. Vorträge*, No. 6.) *Leipzig, Vogel*, 1887, 24 pp.

A VERY good clinical lecture with illustrative cases. MICHAEL.

**KÖHL** (Zurich).—On the Causes which prevent Removal of the Tube in Children Tracheotomised for Diphtheria (Difficult Décanulement). *Inaugural Dissertation, Berlin* 1887 (*reprinted in Laugenbecks Archiv.*, 1887), 149 pp.

THIS essay is very commendable, it reviews the literature of this subject completely, and the matter is collected with great diligence, and is further supplemented with some original cases. Instead of the term, "Impossibilité d'enlever la canule" (Trousseau) the author has invented the expression "difficult décanulement," a rather useful expression, and also the name "retracheotomy" for a second tracheotomy in the same patient. The author very truly says that there are various causes leading to difficult "décanulement," and relates the following with illustrative cases occurring in the practice of others, and observed by himself: (1) Diphthérie à forme prolongée (cases of Gassicourt and two original cases); (2) Relapsing diphtheria (2 original cases); (3) Chorditis inferior (case of Michael and one of his own); (4) Granulation stenosis (Bouchut, Calvet, Millard, Hemev, Meyerson, Rouzier-Joly, Gassicourt, Krishaber, Pauli, Passavant, Fiechter-Jung, Wanscher, Flenier, Neukomm, Socin, Sanné, Kuster, Demme, Boeghold, Hüter, Bergeron, Koch, Körte, Sendler, Trousseau, Thomas, Becker, Boecker, Monti Krönlein, Settegast, Socin, Hagenbach, Voigt, Krabbel, Tillmann, Plenio, Basler, Pruner, Walzberg, Debove, Fournier, de la Harpe, Kocher, Archambault, Reifer, Stoerk, Passavant, Gegeon, Revillod, Hugonnai, Billroth, and twenty-three original cases). He proposes the following prophylactic rules:—(a) The "high operation" of tracheotomy should be performed, (b) The opening should be neither larger nor smaller than the canula. (c) The "décanulement" should be tried daily, commencing on the third day. (d) In removing the canula the wall of the trachea should not be turned up. (e) A phonatory canula shall not be applied. (f) The granulations must be treated by nitrate of silver.



(5) Curvation of the tracheal wall (cases of Ruprecht, Guyon, Passavant, Flenier, and some original cases). (6) Relapse of the anterior tracheal wall (cases of Michael, Rosenthal, Meusel, Passavant, Paris, Boeckel, Settegast). (7) Compression-stenosis (Boeghold and one original case). (8) Cicatricial stenosis (cases of Zimmerlin, Dupuis, Passavant, Volker, Stoerk, Genlit, Lefferts, Simon, Körte, Plenio, Flenier, Blauche, Steiner, Settegast, Boeghold, and two of his own). (9) Primary and secondary paralyses (Gerhardt, Blake, Rehu, Türk, Müller-Warneck, Barkcher, and one of his own). (10) Paresis from habit. (11) Moral influence. (12) Spasm of the glottis (Meyerson, Mackenzie, Boeckel, Wanscher, Bergeron, Rhyn).

Sometimes more than one of these various causes are combined. A good many examples of these are given. The therapy of the stenosis consists in dilatation by dilators (Trousseau, Schrötter, Bird, Stoerk), by bougies (Schrötter, Trendelenburg, Kappeler), or dilating canulas (Stoerk, Richet, Baun, Dupuis, Passavant, Flenier, Gresswell). The paralysis must be cured by electricity, nourishing food, strychnine, and brucine; the paralysis from habit and fear, by moral influence and frequent attempts at removal of the canula; the spasm by morphia or antirachitic treatment. A table illustrates the different forms and effect of the several dilating instruments. It is to be regretted (but this is not the author's fault) that only in very few cases a laryngoscopical examination was made. Certainly this is not possible in all cases, but without doubt it could be made in the majority of such cases.

MICHAEL.

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## TONSILS, PHARYNX, &c.

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**KNIGHT, C. H.**—**The Galvano-Cautery in the Treatment of Hypertrophied Tonsils.** *New York Med. Journ.*, Sept. 24, 1887.

THOUGH the risk of hæmorrhage after tonsillotomy in children has been over-estimated, it is nevertheless one of the chief objections to the operation. There are two methods of operating by cautery—1. By cautery puncture as practised by Voltolini; 2. By the galvano-caustic snare. In the former a fine point is passed deeply into a crypt, or if the crypts are obliterated, it may be passed into the substance of the gland. Not more than three independent lacunæ should be cauterised at each sitting. The pain is not severe, and the inflammatory reaction is seldom excessive. By the fourth or fifth day all local disturbance will have subsided, the eschar may be partially detached and the operation repeated. The largest tonsils

may thus be destroyed in from five to ten sittings. Krishaber, at Milan in 1880, said he had been obliged to use Paquelin's cautery fourteen times in one case. The galvano-cautery would be much quicker than this. Preliminary use of 10 per cent. cocaine, and after use of carbolized alkaline gargles may be required in some cases. Galvano-caustic écrasement is much more rapid, and naturally more painful than cautery puncture. The amount of tissue removed by the snare does not represent the total effect of the operation, since the parts left behind are cauterized to a considerable depth. A single case of hæmorrhage after the use of the snare has been reported by Capart. Two precautions are necessary; the current should be used intermittently, and traction should be made on the loop only during passage of the current. If any unevenness of surface remain, it may be smoothed down by cauterizations. Dragging the tonsil from its bed by vulsellum, or mouse-toothed forceps, or by transfixion needle, will provide that all may be included in the loop: 30 platinum wire is the most serviceable. The use of the galvano-cautery in very young children will be found impracticable except under general anæsthesia. It should be used in all adults and in all cases in which there is risk of hæmorrhage, objection to the knife, or abnormal adherence of the tonsil to the faucial pillars. (See p. 394.)

**RICE, C. C.** (New York).—**Glandular and Connective Tissue Hypertrophies of the Lateral Walls of the Pharynx.** *New York Med. Journ.* Sept. 17, 1887.

THESE conditions are not sufficiently differentiated from coincident affections of the tonsils and fauces. The author has frequently noted a complete tissue connection, of hypertrophic nature, between the enlarged faucial and pharyngeal tonsils,—overgrowth having extended in upward and downward direction these two organs have met. The author is not thus speaking of the raised connective tissue and glandular folds frequently seen running up and down parallel with the posterior pharyngeal pillar. Chronic follicular pharyngitis of the lateral walls of the pharynx is the commencement of this pathological process, and it is met with in young adults of 12 to 18 years of age. The whole tract of glandular tissue is nourished by one blood-supply, and destruction of any part of the chain, by knife or cautery, leads to atrophy of the rest. A second condition spoken of by the author is the so-called "pharyngitis lateralis," or hypertrophy of the plica salpingo-pharyngea. There are two inflammatory affections of the lateral pharyngeal wall which are distinct. One is acute inflammation of the simple follicles, just behind the posterior pillar, coincident with acute follicular tonsillitis. They disappear together, leaving a

narrow superficial line of red raised tissue running up the side of the pharynx. The second form is a hyperplastic inflammation of the mucous and submucous structures at this point (salpingo-pharyngeal fold). This enlargement is liable to give rise to many unpleasant symptoms, *e.g.*, rawness, soreness, burning, fatigue of the voice, cough, glottic spasm, etc. These symptoms disappear with the destruction of this ridge by cautery or caustics.

The pathological affections of this tract demonstrate that the upper and middle portions of the pharynx are part of the same tract. (See p. 393.)

**KNIGHT, F. J.** (Boston).—**Sensory Affections of the Throat.**—*New York Med. Journal*, August 27, 1887.

His experience is chiefly with hyperæsthesia and paræsthesia. He considers that hyperæsthesia is usually due to a constitutional vice, generally alcohol, which disappears with abstinence from alcohol; and occasionally from granular pharyngitis, which is relieved quickly only by combining local and constitutional treatment.

He refers to the probable cause of some cases of paræsthesia as being due to paralysis of one set of the hyoid muscles, the motor-nerve supply for each set of muscles being received from entirely different sources. Treatment is to be specially directed to constitutional vice. (See p. 389.)

**GAIRDNER and COATS** (Glasgow).—**Perforation of the Œsophagus and Penetration of the Aorta by a Fish-Bone; Fatal Hæmorrhage.**

*Glasgow Medical Journal*, July, 1887.

EXHIBITION of specimens before the Pathological and Clinical Society of Glasgow, 13th December, 1886. In the œsophagus, at a point about  $2\frac{1}{2}$  inches below the level of the bifurcation of the trachea, were two oval apertures—one on either side—which communicated on the right side with a large cavity which passed towards the root of the lung, and on the left side with a cavity which passed more upwards than downwards, and lay chiefly between the œsophagus and the aorta. The left cavity contained blood, and shreddy decomposing matter. In the aorta was a very ragged irregular aperture, situated directly in a line continued from the middle of the aperture on the right through the middle of that on the left side.

The history of the case having pointed to a fish-bone, which had been swallowed nine days before death, as the cause of the perforations, diligent search was made for it, but without success.

In the discussion which followed, Prof. Gairdner remarked upon the important fact observed in this case—that the patient had lived for some hours after penetration of the aorta had taken place, and he

observed that there are, or may be, possibly favourable conditions under which such a breach might be permanently healed. He referred to some cases which show that fish bones were at least possible sources of danger long after the period of swallowing. Dr. Finlayson referred to a case of perforation of the œsophagus which had been under his care, but no details were given.

HUNTER MACKENZIE.

**LANGMAID.**—**Constitutional Causes of Throat Affections.** *Medical News*, June 25, 1887.

IN lesions of the throat there is some underlying cause, which may be external or intrinsic. Too much attention having been directed to the local condition and to atmospheric conditions, it is worthy of study why atmospheric conditions are active at one time and not at another. Chronic recurring coryza is one of the most intractable diseases which we have to treat. As a rule the treatment must be general, though sometimes destruction of the mucous membrane of the nose is sufficient. The sense of a lump in the throat so often complained of is an indication of an overloaded colon, and more good is done by a dose of castor oil than by local treatment. Clergyman's sore throat, or follicular laryngitis, arises not in the necessary use of the throat but in the sedentary life which, with errors of diet and other conditions, plays an important part. Throat trouble is sometimes a rheumatic or gouty manifestation, and treatment must be directed to this condition. Local treatment in many throat troubles is of the nature of repair; constitutional and hygienic treatment must be directed towards the renewal of the normal processes. Swellings and congestions of the mucous membrane, hypertrophy of the tonsils, elongation of the uvula, must be regarded as symptoms which will not be banished except the underlying constitutional malady is removed. (See p. 395.)

**DEBOVE.**—**Simple Ulcer and Cicatricial Stenosis of the Œsophagus.**

*Soc. Méd. des Hôpitaux*, August 12, 1887.

THE author made an autopsy on a man in whom, in 1885, a cicatricial stenosis of the œsophagus had been diagnosed, to all appearance simple, but in reality due to an ulcer of the œsophagus. The latter, at a distance of five centimetres from the cardia, presented a cicatricial fibrous band, which had been successfully dilated in 1885; there was, moreover, a gastric ulcer seated near the lesser curvature, which had not been diagnosed during life. It is interesting to observe that there can exist œsophageal strictures, simple in appearance, but which could be thought to be cancerous, and which are of good prognosis if the treatment by dilatation be instituted in time. JOAL.



## NOSE AND NASO-PHARYNX.

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**MACKENZIE, J. N.** (Baltimore).—**The Pathological Nasal Reflex. An Historical Study.** *New York Med. Journ.*, August 20, 1887.

THE connection between the nose and diaphragm was known to Plato and Hippocrates, and that between the nose and eye to Aristotle. The dependence of catarrh, coryza, asthma, syncope, convulsions, &c., upon the odours of certain flowers was well known to the ancients, and Galen was acquainted with the fact that various foods in certain people produced coryza. Bostock was certainly not the first to describe "hay fever," which was perfectly well known to the ancients. It is true also that Aurelian, Zecchius (1650), Schneider, Floyer (1726), Bree (1811), Trousseau, Follin, Duplay, and Ferber (1869) were thoroughly well acquainted with the connection between asthma and inter-nasal disease long before Voltolini, in 1871, wrote of the connection (and to whom is erroneously attributed the credit of this observation). Epilepsy was known to be associated with intra-nasal irritation by the ancients, and Fernelius, in 1668, showed the connection between hemicrania and catarrh. In 1682 Wedel treated of the connection between vertigo and sneezing, and Helmont in the same year, described the production of asthma, hemicrania, palpitation, syncope, epilepsy, cough, vomiting, and other complaints from the inhalation of odours. "Rose cold" was recognized towards the close of the seventeenth century by Binningerus and Ledelius. Gumprecht, in 1717, attributed these troubles to affection of the fifth pair of nerves.

J. J. Wepfer, in 1728, published a large work full of illustrative cases of various pathological phenomena related to nasal inflammation and obstruction. Langhaus, in 1749, attributed these reflex phenomena to the superior cervical ganglion. Whyte, in 1765, advanced to the doctrine that the peripheral impressions were conveyed to the sensorium before being reflected to other parts of the body. Quotations from other authors bring the historical essay down to 1819, when Bostock was supposed to have discovered "hay fever."

[The author must be congratulated upon having produced a most scholarly and instructive essay, and we can only hope that he will be encouraged to produce others of the same kind. Though we know that the labour and patience necessary for the undertaking of such literary researches are immense, Dr. Mackenzie may be assured of the appreciation in which such efforts are held.] (See p. 387.)



**GLASGOW, W. C.** (St. Louis).—**On Certain Measures for the Relief of Congestive Headaches.** *New York Med. Journ.*, Sept. 3, 1887.

THE author means the pain and sense of constriction felt at the forehead and temples due to over-distension of nasal vessels. It is frequently associated with the menstrual period, and is due then to distension of the cavernous bodies. The degree of tension of these bodies corresponds with the severity of the headache. The author treats these cases by abstraction of blood by pricking the cavernous body so as to permit of the free flood of a drachm to an ounce or even more. Cases in illustration of the point are given. (See p. 391.)

**DELAVAL, B.** (New York).—**The Treatment of Atrophic Rhinitis by Applications of the Galvanic Current.** *Medical News*, June 4, 1887.

THE treatment of this complaint is very discouraging. The author has therefore adopted the treatment recommended by Dr. E. L. Shurly—viz., by the use of the galvanic current. The positive pole of the constant current battery was applied to the nape of the neck, and the negative pole directly to the mucous membrane by an electrode consisting of a copper wire round which absorbent cotton is wrapped. The strength of the current employed varies from four to seven milliamperes. In recent cases of the affection the effect is marked, and in the older cases is also beneficial. The objection is the time that it employs. (We have ourselves used this plan of treatment with much benefit, but have seen bleeding and much soreness, and even considerable after-pain, more than once, resulting from the use of the Faradic current. (See p. 388.)

**JARVIS, W. C.** (New York).—**Two Unique Cases of Congenital Occlusion of the Anterior Nares.** *Medical News*, June 25, 1887.

THE first case was a man eighteen years old with complete closure of both nostrils. On each side a cup-shaped depression of white glistening membrane within the anterior nares was seen; a small hole perforated the left one. The cartilaginous occlusion was cut through at two operations with the author's burrs and engine. A year later the operation had to be repeated in the right nostril. In the second case the occlusion of the nostrils was due to an osseous formation, and the same operation was successfully performed. (See p. 396.)

**MACCOY, A. W.** (Philadelphia).—**A Comparative Study of some of the Methods of Treatment best adapted to the Relief of the Posterior Nares.** *Medical News*, June 25, 1887.

THE remarks were confined to obstructions due to enlargement of the soft parts. The author highly recommended the use of

chromic acid, fixed on the end of a probe the end of which is covered with a tube, which can be withdrawn when the probe has reached the position required. An antagonistic solution is then used. The author finds this better than the use of the galvano-cautery. The cold wire snare could not be used after application of cocaine, on account of the contraction caused by this drug. Jarvis's needles were applied with difficulty. (See p. 396.)

**ROBINSON, BEVERLEY.**—**Note on a Frequent Cause of Nasal Hæmorrhage.** *New York Med. Journ.*, Sept. 24, 1887.

THE author refers to the epistaxis, often very troublesome and recurrent, occurring in the course of atrophic rhinitis. Frequently plugging is resorted to; but anterior plugging often allows oozing alongside the plug. Posterior and anterior plugging arrests the hæmorrhage for a time, but it recurs after withdrawal. The cause of the hæmorrhage is erosion or ulceration of the mucous membrane covering the nasal septum, often perforating a septal artery. Sometimes there is no erosion at all. The author relies upon the internal administration of ergot and digitalis (ext. ergot two or four parts, tinct. digitalis one part; guttæ x.—xx., every few hours in the intervals of the hæmorrhage, every ten to fifteen minutes, or in one or two large doses, during continuance of the hæmorrhage). He has had good results from antipyrin, in five, ten, or fifteen-grain doses. Locally he relies upon hot water, and principally upon plugging the anterior nares, with strips of the oak agaric (*Boletus igniarius*). It is rarely necessary to introduce a posterior nasal plug. For the application he prefers Steele's flexible probe. Curative local treatment is:—  
1. Abandon the use of every kind of spray or douche to separate the crusts. 2. Rely for this purpose on ointments which soften the crusts in a few days so that they can be removed by blowing the nose. The best ointment is white precipitate made with vaseline, and which is applied three times daily with brush or index finger. After removal of the crusts, make occasional applications of copper, silver nitrate, or compound tincture of iodine, to the erosion. A cure of the erosion and epistaxis occurs in one or two months. The galvano-cautery is very pernicious, rendering a slight affection lasting and troublesome, by production of new surfaces which will not heal. (See p. 395.)

**ROE, J. O. (Rochester).**—**Hay Fever.** *New York Med. Journ.*, Sept. 3, 1887.

THE author reports forty-four cases, twenty-seven in males, and seventeen in females. His conclusions are as follows:—

1. That all cases of hay fever have their initiatory lesion in a diseased condition of the tissues of the nasal fossæ.

2. That the disease of these tissues induces, in the ganglionic centres connected with them, an abnormal activity, which is reflected to other tissues and organs.

3. That the sensitive areas in the nose are not confined to any particular locality, and that there are no zones in the nose which when irritated invariably produce the same manifestations.

4. That the direction in which the irritation is reflected is, like an electric current, always along the line of least resistance, and that from the same region it may be reflected in one direction at one time, and in the opposite direction at another time.

5. That the disease in the nose may produce disease in other portions of the respiratory tract, which may become independent centres of irritation.

6. That the affection distinctly recognized as hay fever is due to the effect of a local irritant, brought by the atmosphere in contact with the sensitive regions of the air-passages.

7. That the affection is not *per se* a neurotic disease, nor necessarily associated with a nervous temperament, although persons having a highly nervous temperament or a neurosis are much more susceptible to the influence of a local irritant.

8. That the neurotic condition which is often regarded as a cause of hay fever is itself often developed as the result of the local irritation.

9. That by carefully correcting all abnormal conditions found in the nasal or other portions of the respiratory passages, and the use of such systematic medication as may be required to remove any associated or consequent general derangement, we need not fail to cure hay fever. (See p. 387.)

**LINCOLN, RUFUS P.** (New York).—Case of Recurrent Naso-Pharyngeal Tumour cured by Electrolysis. *Medical News*, June 25, 1887.

A GROWTH had been removed from the posterior nares one year previously, and the operation was repeated six months later, the patient again coming under observation. A large growth was now found to occupy the left half of the posterior nares; this was treated by electrolysis with two needles of the negative pole introduced through the anterior nares, the positive pole being applied to the chest. Sixteen applications were made, at intervals of three or four days, and the growth entirely disappeared. (See p. 396).

## LARYNX.

**DONALDSON, Jun., FRANK.**—Further Researches upon the Physiology of the Recurrent Laryngeal Nerve. *New York Med. Journ.*, August 6, 1887.

THE author criticises Hooper's paper, insisting that he does not once allude to any *peripheral* effect of *ether* on the laryngeal muscles, and that Hooper's conclusion, that abduction was normal, provided consciousness was abolished, was unjustifiable. Donaldson avers that the stimulus 3, which Hooper says he used, will always give *adduction* of the cords, and that Hooper failed all along to see that he was dealing with a peripheral, and not a central effect. Donaldson affirms that his present experiments prove:—1. That an abduction of the vocal bands, a dilatation of the glottis, can be obtained without ether. 2. That opening or closing of the glottis depends upon the strength of the current. 3. That every statement made in his original paper is confirmed.

According to his experiments, abduction follows the use of weak, adduction of strong stimuli, in every case. The more irritable abductors also die first, and these are the muscles which respond to weak stimuli. The same is proved by Bowditch for the flexor and extensor muscles of the frog's leg. It is not, however, possible yet to say whether the difference in irritability lies in the muscles or nerves. The author now believes that those cases in which the vocal band is found fixed in phonatory position are true paralyses of the abductor muscle, and not spasm of the adductors, for in cases of unilateral or bilateral lesion of the cords from an aneurysm or tumour, the constant pressure upon the nerve acts as a mechanical stimulus to it, and the more irritable abductors are the first to respond (see p. 389).

**HOOPER, F. H. (Boston).**—The Anatomy and Physiology of the Recurrent Laryngeal Nerves. *New York Med. Journ.*, July 9, 1887.

As far as dogs and cats are concerned, the recurrents are purely motor nerves, and stimulation with weak currents does not lead to a rise of blood-pressure, as is the case with other sensory nerves.

The author enters into an elaborate discussion of the anatomy and relations of the nerve, for which the original must be consulted. There are in the larynx three distinct functions controlled by three distinct groups of muscles, all innervated by the recurrent nerves, viz.:—1. Those that carry on the respiratory function of the larynx. 2. The sphincter group. 3. The phonatory group. The recurrent laryngeal, therefore, contains three sets of fibres presiding over these



functions. Having no definite knowledge of the numerical or typographical relations between dilating and constricting fibres, we cannot be positive when we apply a current of electricity to the nerve, that we are stimulating all of its component fibres equally and simultaneously. We should expect the nerve fibres which regulate the action of the largest group of laryngeal muscles, viz., the respiratory, to be most numerous, sensitive, and resistant, and easiest called into action. But this is not universally the case. The cat is peculiar. Contrary to the dog, the earliest effect of a weak stimulus to the recurrent is to produce a tendency towards dilatation, merging into rigid dilatation as the strength of the stimulus is increased. While, in the cat, the function of the recurrent under normal conditions is to open the glottis, it is in the dog to close the glottis. The normal function of the recurrent nerve in man is therefore difficult to determine.

The general result of experiments made upon the human subject is to show that the recurrences close the glottis on stimulation. The effects observed in dogs and cats can be reversed under ether and profound morphine narcosis. The author refers to Donaldson's inability to obtain the "ether effect," and to Semon and Horsley's verification of his original statement. They obtained the effect only in cases where the animal was not deeply etherized. In certain stages of etherization, the effect varies with the intensity of the current, *i.e.*, abduction is produced by weak stimulus, and adduction by stronger currents. It is, however, impracticable to use strong stimuli in experimental laryngeal physiology. Fresh researches have been conducted by the author on forty-two dogs, comprising 300 recorded experiments. But little is added to the author's previous experiments upon the "ether effect." The facility with which dilatation is obtained depends upon the susceptibility of the dog to the drug, the intensity of the irritation, and the amount given. It differs in different dogs. In the majority complete dilatation may be elicited; in others, only the mixed movement is obtainable; in two dogs the effect has been negative, but closure took place with slight anaesthesia. The author then describes at length his method of experimenting, and gives details of the experiments. Perkins and Ellis, experimenting upon the sciatic of the frog, have found that stimulation under ether produced opposite effects from experiments without ether, and Professor Bowditch has concluded that the "ether effect" is a phenomenon dependent upon the action of the ether upon the nerve trunk due to paralysis of an elective character of certain nerve fibres.

Applying the same method to the recurrent nerve of the dog, viz.,



local application of ether to the nerve, in chloralized animals Hooper was unable to obtain in any (of seven dogs) a dilatation. As the nerve became paralysed with the ether it required more powerful stimulus to produce contraction. The cause of the "ether effect" is not to be sought in the nerve trunks.

In cats, of course, no "ether effect" can be obtained, since abduction takes place equally well under chloral, morphine, chloroform, or ether. Dilatation of the glottis is the rule when recurrent or pneumogastric nerves are stimulated, or their peripheral ends after section. But after death the abductions grow more feeble, and closure more prominent. During asphyxia dilatation is invariably the case even when cyanosis is extreme and respirations have ceased. A closure can only be produced reflexly by stimulation of the central end of the cut vagus. The results were constant in twelve cats. (See p. 389.)

**INGALS, E. F.**—Intubation of the Larynx. *New York Med. Journ.*, July 2, 1887.

THE author gives a historical survey of the subject, referring especially to Bouchut's original attempts, in 1858, to introduce intubation, and which was condemned at the time by Trousseau, and to O'Dwyer's experiments commenced in 1880. He has treated twelve cases of diphtheritic laryngitis by intubation. In the only three cases in which he had subsequent care of the patient, recovery followed. One lived for eight days, and died suddenly; another lived eight days and died of pneumonia. The author advises that (1) all foods should be prohibited except by enemata; (2) some preparation of mercury in large and frequent doses should be administered; (3) in case of the development of bronchitis or pneumonia, respiratory and cardiac stimulants should be given freely, but judiciously. The author has obtained reports of 514 cases, in 134 of which, or  $26\frac{7}{100}$  per cent., recovery has followed. The following conclusions are arrived at from a study of these cases:—

1. Intubation may be quickly and easily performed, and with but little danger.
2. Friends readily consent.
3. There is no necessity for tedious after-treatment, as the tube is kept clear by the respiratory efforts.
4. The results are practically as good as tracheotomy at all ages, and apparently better in very young children.
5. Great care must be taken to prevent the entry of foreign substances into the trachea.
6. With O'Dwyer's tubes, deglutition of fluids should be forbidden while the tube is in the larynx. Ice and soft solids may be given; fluids, if necessary, may be given by enemata, or the tube may be removed while feeding, and re-introduced afterwards.
7. Tubes with smaller heads, designed to rest on the cords, have not been used

sufficiently to entitle a positive opinion about them. If experience proves that they do not slip into the trachea, they will, however, obviate the difficulty of feeding the patient. 8. Medical treatment after intubation must be carefully attended to. 9. Long tubes are preferable to short tubes, as less liable to be filled with membrane. 10. Intubation may and should be practised early, and does not preclude subsequent tracheotomy. 11. For serious cases of spasmodic croup, and for œdema of the glottis, the procedure will prove most useful. 12. The same may be said for treatment of chronic laryngeal stenosis. (See p. 386.)

**SAJOUS, C. E.** (Philadelphia).—**A Study of the Principal Objectionable Features of Intubation.** *New York Med. Journ.*, July 23, 1887.

INTUBATION is encumbered with some real defects, which will doubtless be remedied as the method grows in use. The principal objections are :—

1. Obstruction of the tube by fragments of membrane.
2. Crowding down of loose membrane during introduction of the tube.
3. Passage of food through the tube into the trachea, and consequent inability to feed through the mouth.
4. Momentary arrest of respiration during introduction and consequent shock.
5. Liability of the tube to be coughed out, and slipping of the tube into the trachea.

The first defect is caused by (1) limited diameter of the interior of the tube ; (2) its internal conformation. The second accident is caused principally by the length of the tube. The third defect, the author thinks, is not due to the impediment offered to the free action of the epiglottis, by the presence of the tube, but to the weight of the tube preventing the ascent of the larynx. The fourth accident is due to the presence of the obturator. The fifth accident is due to the small diameter of the tube, rendering it liable to be coughed out of the larynx like a foreign body. Slipping of the tube into the trachea is due to the narrowness of the head, combined with the weight of the tube. The author has therefore devised a set of tubes which, when *in situ* in the larynx, present the shape of the capital letter A with a funnel at the top. He has also devised forceps, and an instrument for the purpose of withdrawing detached membrane from the trachea. So far the author has only used the tubes upon the cadaver. (See p. 386.)

**SOLIS-COHEN, J.**—**The Treatment of Laryngitis in Professionals who are unable to rest.** *Medical News*, June 18, 1887.

IN order to restore the voice of a professional who comes with hoarse-

ness, the result of acute laryngitis, the author finds the best method is to give a sharp emetic, then let the patient rest until the time of the performance sucking ice, and keeping a cold compress to the neck. For chronic laryngitis he had found a weak solution of sulphate of zinc (two grains to the ounce) in spray the most useful. In the intervals of the play the performer may inhale a little compound tincture of benzoin, if he finds himself somewhat hoarse. Another remedy of considerable service is the use of a respiratory with turpentine, terebene, eucalyptol, or similar medicaments. He sometimes directs the patient to sprinkle a little turpentine on the bedroom floor, but is not aware of any special method adapted to this class of individuals. (See p. 392.)

**GRÜNWARD** (München).—**Combination of Syphilis and Tuberculosis in the Larynx.** *Münchener Med. Wochenschr.*, Nos. 21, 22, 1887.

THE author relates, in a very detailed and careful manner, the individual signs of tuberculous and syphilitic affections of the larynx, communicates some illustrative cases, and concludes in the following manner:—If we find in a larynx evidently contracting cicatrices and along with progressive destruction, especially on the outside of the epiglottis, and we also find papillary tumours on the interarytenoid space which are actively growing or recurrent after operation, we can be sure that there is a combination of syphilis and tuberculosis.

MICHAEL.

**ASCH, MORRIS J.**—**A Case of Stenosis of the Larynx, Treated by Divulsion and Systematic Dilatation.** *Med. News*, June 25, 1887.

THE patient was a young woman of twenty-seven, with a history of pulmonary trouble but no other condition. There was wheezing cough and dyspnoea, increased by lying down. There was nothing abnormal in the larynx or above the cords. Two white swellings, united by a membrane posteriorly, were, however, seen below the cords; the opening of the larynx was diminished to one-third of the normal size. The membrane was cut and divulsion performed, causing great improvement. Being much better she ceased attendance. A few months after she returned with the dyspnoea as great as before, the result of acute laryngitis. The introduction of O'Dwyer's tubes produced spasm and cough. Schroetter's hard rubber tubes were then used, and within three months the cure was perfect, and all symptoms have now disappeared. (See p. 395.)

**BEAN, C. E.** (St. Paul).—**A Case of Recurring Hæmorrhage of the Vocal Cord.** *New York Med. Journ.*, Sept. 24, 1887.

THE patient was under treatment for chronic hypertrophic rhinitis, follicular pharyngitis, and superficial inflammation of both cords, and discharged relieved in three months. He returned with inflam-

mation of the vocal cords, and was again cured. Two months later he returned with the same complaints, having had to use his voice more than usual, and had constant coughing for a day from inhalation of dust. The left vocal cord was normal, the right one swollen and dark red. The cure was effected in two months with zinc sulphate (lx. gr. ad ʒj.), and nitrate of silver (xxx.—lx. gr. ad ʒj.). Three months later the condition recurred. Zinc, as before, cured the condition in a month. Five months after, all the symptoms had recurred. The right cord was again of dull red colour. Ergot ( $\frac{1}{2}$  gr. t. d.) was given, without local application, and in three weeks the cords became normal.

There was no lung trouble whatever. (See p. 397.)

**MAJOR, G. W.—Affections of the Crico-arytenoid Articulation.**

*New York Med. Journ., Sept. 24, 1887.*

THE principal affections alluded to by the author are—sprain, dislocation, direct local injury, acute inflammation, and ankylosis. Sprain may result from sudden closure of the larynx during forced swallowing. Dislocation is rare, more particularly as the result of direct violence. The author cites a case in which it was due to pressure on the cricoid cartilage, and a second case in which, owing to immobility of the left vocal cord, a rough but useful voice is produced by approximation of the right vocal cord and ventricular band of the left side. Acute inflammation of the joint is met with in rheumatic and gouty attacks, tonsillitis, measles, scarlatina, croup, bronchitis, and other acute disorders. Ankylosis of the joint is the affection most commonly met with. Its causes are numerous, e.g., chondritis or perichondritis (primary or by extension), syphilis, typhoid, rheumatism, gout, exanthemata, and catarrhal conditions of the air-passages. The most common cause is rheumatic or catarrhal inflammation of the joint. Every possible degree of ankylosis may exist, from barely perceptible impairment of movement to absolute immobility. The most important influence is exerted by the point at which ankylosis is accomplished, as regulating respiration and phonation. The symptoms, which closely resemble those due to paralysis, are then discussed. The differentiation is important. Tenderness on pressure over the crico-arytenoid region, possibly some enlargement of the joint capable of being felt externally, swelling or enlargement as seen by the laryngoscope, the sensation of roughness to palpation, or friction sound assist the diagnosis of ankylosis. The absence of these signs favours paralysis. Difficult deglutition is characteristic of many cases of marked ankylosis. The treatment consists in frictions of biniodide of mercury over the crico-arytenoid region, the local use of astringents or weak solution of iodine in



glycerine, iodide of potassium, and galvanism. Massage is also beneficial. (See p. 397.)

**ARCHAMBAULT.**—**Fifty Centime-piece in the Larynx.** (From Dr. Fauvel's Clinic.) *Gaz. des Hôp.*, August 25, 1887.

THE patient, a coachman, came to Dr. Fauvel on June 9, having swallowed the coin two days before. He was extremely pallid, and exhibited the greatest anxiety. The neck was very sensitive to palpation, and the slightest pressure at the level of the thyroid and cricoid cartilages produced great pain. Violent attacks of suffocation occurred, dyspnoea was extreme, and it was impossible to take the least nourishment, deglutition provoking intense pain. Attacks of cough were frequent and very painful, and aphonia was complete.

The fifty-centime piece was found laryngoscopically to be situated in the ventricles, the inferior aspect reposing upon the vocal cords, and between the posterior edge and the interarytenoid region was a space of two to three millimetres. Various efforts at extraction with the forceps being unavailing, the intra crico-thyroid space was opened, the thyroid cartilage incised up to the level of the vocal cords, the coin was seized with forceps and drawn out. Twenty days after, the wound had completely cicatrized, the patient was cured, and the voice was normal.

JOAL.

**JOHNSON, H. A.** (Chicago).—**Cancer of the Larynx.** *New York Med. Journ.*, Sept. 24, 1887.

THE relation of five cases, from which the author draws the following conclusions:—

1. All the five patients were males, the youngest forty-five years old.
2. The growth was from the right side in three cases, from the left in one, and probably in the other.
3. In only one case was there a family history of cancer (viz., the patient's mother).
4. In one case the disease seemed to be secondary to extension from outside.
5. In only one case was there any evidence of infection of the lymphatics from the larynx.
6. In only one case was there any troublesome hæmorrhage.
7. In no case was there marked pain in the larynx.
8. In three cases, tracheotomy was performed, and the patients' lives prolonged, three, five, and eight months respectively. (See p. 397).

**CHAPMAN, S. H.** (New Haven).—**Myalgia of the Pharynx and Larynx.** *New York Med. Journ.*, August 27, 1887.

CHAPMAN specially limits the use of the word to a certain painful condition of the muscles, produced by inhalation of impure air. In



the initial stage there is a sense of uneasiness ; this does not amount to pain even on motion, but on pressure gives decided pain : in the former it differs from muscular rheumatism.

The second important symptom is a sense of loss of power in the affected part. This is specially noticed when the affection is unilateral in the muscles of the chest, or the muscles of deglutition. He concludes that the pressure of solids in the act of swallowing gives rise to the pain, and that the difficulty of swallowing vanishes under the use of fluids.

Usually the sensation of uneasiness and loss of power is denoted by a suppressed vocal intonation.

The third symptom is an irritable pulse, increasing to cardiac palpitation in cases of long standing or of severity.

The fourth symptom is tenderness, more or less marked, in the region of the spleen.

He locates its nature and cause by tracing its origin to malarial atmosphere, and its cure to anti-malarial germicide treatment.

He gives four cases from his note-book substantiating his theory and practice. (See p. 389.)

**GLASGOW, W. C.** (St. Louis).—**The Etiology and Mechanism of Asthma.** *Am. Journal of the Med. Sciences*, July, 1887.

IN 1885, Glasgow described a condition of the nasal mucous membrane characterized by extreme pallor, swelling, and œdema. When irritated, the swelling is increased and a thin watery discharge is poured out. The condition promptly subsides, after the inhalation of amyl nitrite, ether, or the instillation of morphia and atropia, but remains unchanged after the application of cocaine. The subjects are of a marked neuro-vascular temperament, and the condition of the mucous membrane differs from that ordinarily encountered in coryza vasomotoria. In the latter condition there is hyperæmia, with dilatation of the vessels, but in the former the pallor completely negatives the idea of dilatation. The action of the above drugs indicates rather a spasm of the arterioles, and Glasgow assumes that the condition is one of vasomotor spasm. He believes that an analogous condition may exist in the mucous membrane of the bronchi during asthmatic attacks. This theory derives support from the observation that examination with the mirror during the asthmatic paroxysm reveals often a pallid and swollen condition of the pharyngo-tracheal membrane. He would, then, consider asthma a disorder of vascular irritability ; that the paroxysm is directly due to a partial occlusion or cylindrical narrowing of the lumen of the bronchi through the swelling of the bronchial membrane ; that this swelling is caused by a vasomotor spasm of the arterioles with a

saturation of the tissues by the liquor sanguinis; this condition is accompanied by a general high blood pressure. The author devotes considerable space to the description of the asthmatic paroxysm, and prefaces his article with a brief *résumé* of recent theories on the subject.

JOHN N. MACKENZIE.

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## NECK, &c.

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**DEBOVE.**—**Exophthalmic Goître and Hysteria.** *Soc. Méd. des Hôpitaux, August 12, 1887.*

THE author cites the case of an hysterical man, in whom, some time after the access of nervous symptoms, all the signs of exophthalmic goître appeared. It was of the undeveloped variety, but was none the less evident. The thyroid was not enlarged certainly, but was painful to pressure, exophthalmus was very manifest, and the cardiac pulsations were rapid, amounting to 120 to 140 a minute. The author has observed in women a large number of cases in which hysteria and goître were simultaneous. In men, however, the coincidence is rare.

JOAL.

**CARDONE, F.**—**Hypertrophy of the Thyroid Gland concurrently with Atrophy of the Spleen.** *Arch. Ital. di Laring., 1887.*

CARDONE relates two observations—(1) A woman with degeneration of the spleen, the result of *malaria*; (2) a woman with a voluminous tumour of the spleen. In both cases occurred, concurrently, an enlargement of the thyroid gland. The author, after having shortly discussed the functions of the thyroid gland (and he relates observations and experiments made latterly), is of opinion that there is a physiological relation between thyroid gland and spleen, and that the enlargement of the former, observed by him in the cases related, was to be considered as a compensative hypertrophy. He, however, does not deny that the experimental proof is wanting. He has the intention of undertaking this, since it will answer, in a certain manner, the important question raised by these observations.

MASSEI.

**PARTRIDGE (Carlisle).**—**Tumour of the Right Parotid Gland.** *Edin. Med. Journal, June, 1887.*

EXHIBITION of patient (a three months' old infant) before the Carlisle Medical Society, 10th March, 1887.

HUNTER MACKENZIE.

**McGILL, A. F. (Leeds.)**—**Remarks on Four Cases of Excision of the Tongue.** *Edin. Med. Journal, August, 1887.*

THESE cases are recorded to "illustrate the advantage that is gained by the performance of a preliminary laryngotomy, and the recovery which follows excision by means of the scissors."

HUNTER MACKENZIE.

**MÜHE** (Erbendorf).—**Case of Fistula Colli Congenita.** *München. Med. Wochenschr.*, No. 31, 1887.

IN a new-born child the opening of a fistula of 7 mm. length and 2 ctm. long under the hyoid bone, and 1 ctm. before the sternocleidomastoideus. It was an incomplete fistula with milky secretion. Cured by injection of tinctura iodi. MICHAEL.

**CATHCART** (Edinburgh).—**Epithelioma of the Sublingual Gland.** *Edin. Med. Journal*, August, 1887.

DEMONSTRATION of specimen, which had been removed through the floor of the mouth, before the Medico-Chirurgical Society of Edinburgh, April 6, 1887. The submaxillary gland, which was similarly affected, had been removed at the same time.

HUNTER MACKENZIE.

## ASSOCIATION AND CONGRESS MEETINGS.

### Ninth International Medical Congress,

*Held at Washington, September 5, 6, 7, 8, 9, 10, 1887.*

#### SECTION OF LARYNGOLOGY.

*President*, Dr. W. H. DALY, Pittsburg, Pa.

#### *Secretaries,*

Dr. W. H. PORTER, Dr. RANKIN, U.S.A. ; Dr. O. CHIARI, Vienna ;  
Dr. HERMANN KRAUSE, Berlin ; Dr. E. G. MOURE, Bordeaux.

*Meeting, September 5.*

THE President delivered an inaugural address welcoming the laryngologists present, and contrasting the advance of the science, compared with its status in 1876, and referred to his own observations on the intra-nasal treatment of hay fever, as inaugurating a new method of dealing with this complaint which had been extended later by Hack and others. He declared that laryngologists in future would pay more attention to the surgery of the nasal passages, and the rhinologist would become more of a surgeon than a physician.

The following papers were presented in this section :—

Dr. R. H. THOMAS (Baltimore), *A Contribution to the Causes of so-called Hay Fever, Nasal Asthma, and allied Affections, considered from a Clinical Standpoint.*

Dr. J. P. KLINGENSMITH (Blairsville, Pa.), *Hay Asthma.*

Dr. D. N. RANKIN (Alleghany, Pa.), *Some Remarks on the History of Rhinology.*

Dr. E. F. INGALS (Chicago), *On Epistaxis.*

Mr. LENNOX BROWNE (London), *Recent Views as to the Pathology and Treatment of Tuberculosis of the Larynx.*

Dr. WILLIAM PORTER (St. Louis), *Recurrent Hæmorrhages of the Upper Air-passages.*

Dr. W. E. CASSELBERRY, *Treatment of Laryngeal Papillomata.*

Dr. E. L. SHURLY (Detroit), *The Diagnostic Differentiation of Recent Tuberculosis, Specific and Rheumatic Laryngeal Diseases.*

Dr. E. F. INGALS (Chicago), *Chronic Rheumatic Laryngitis.*

Dr. A. B. THRASHER (Cincinnati), *Resorcin in the Treatment of Nasal Catarrh.*

Dr. H. H. CURTIS (New York), *Surgery of the Nasal Septum and Turbinate Bodies.*

Dr. F. MASSEI (Naples), *Primary Erysipelas of the Larynx.*

Dr. F. SEMELEDER (Mexico), *Twenty Years of Laryngological Work in the City of Mexico.*

Dr. F. B. EATON (Portland, Ore.), *Present Status of the Galvano-Cautery in the Treatment of the Diseases of the Upper Air-passages, illustrated by Instruments and the Description of Cases.*

Dr. W. L. CASSELBERRY (Chicago), *Nasal Fibromata.*

Dr. J. O. ROE (Rochester), *Chorea Laryngis.*

Dr. M. F. COOMBES (Louisville), *The Deleterious Effects of Tobacco on the Throat and Nose.*

Dr. MAX J. STERN (Philadelphia), *Intubation or Tracheotomy.*

Mr. CARMALT JONES (London), *The Action of the Epiglottis in Swallowing.*

Dr. C. SLOVER ALLEN (New York), *A New Snare and Ecraseur.*

Dr. C. M. DESVERNINE (Havana), *The Longitudinal Tension of the Vocal Cords: its Physiology and its Derangements.*

Dr. J. O'DWYER (New York), *Treatment of Chronic Stenosis of the Larynx and Trachea by Intubation.*

Dr. EYE, of Reading, read a paper on *A New Method of Treating Phthisis.*

Sir JAMES GRANT, of Canada, read one on *Diphtheria.*

In the Section in Psychological Medicine, a paper was read by Dr. S. S. BISHOP, of Chicago, on *The Pathology of Hay Fever.*

In the Section in Surgery, a paper was read by Dr. G. ASSAKY, of Bucharest, on *Iodol in Surgery.*

In the Section in the Diseases of Children, M. DE SAINT-GERMAIN contributed some remarks on *Ignipuncture of the Tonsils as a Substitute for Tonsillotomy.*

A paper was also read by Dr. C. W. EARLE, of Chicago, entitled, *An Investigation to determine whether the Absence of Sewerage and of Water Pollution diminish the Prevalence and Severity of Diphtheria.*

A paper was also read by Dr. W. P. NORTHROP, of New York, upon *The Pathological Anatomy of Laryngeal Diphtheria as related to Intubation.*

Another, by BOUCHUT, of Paris, on *Tubage of the Larynx in Stricture, and in the Asphyxia of Croup.*

Another, by Dr. J. O'DWYER, of New York, on *Intubation of the Larynx.*

One by Dr. F. E. WAXHAM, of Chicago, entitled, *Intubation of the Larynx: its Advantages and Disadvantages, with Statistics of the Operation.*

In the Section in Anatomy, Dr. M. J. STERN, of Philadelphia, presented a specimen of *An Anomalous Middle Thyroid Artery.*

In the Section in General Medicine, Dr. G. E. STUBBS, of Philadelphia, read a paper, entitled, *Rational Treatment of Diseases of the Respiratory Apparatus.*

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#### American Laryngological Association.

*Ninth Annual Congress held in New York, May 26, 27, 28, 1887.*

*President, Dr. E. F. INGALS.*

*Vice-Presidents, Dr. E. C. MORGAN and Dr. J. N. MACKENZIE.*

*Secretary, Dr. BRYSON DELAVAN.*

Papers read:—

1. *Intubation of the Larynx*, by E. F. INGALS (see p. 376).
2. *A New Method of Intubation of the Larynx*, by C. E. SAJOUS (see p. 377).

In the discussion which followed, Dr. F. H. HOOPER, of Boston, gave the record of ten cases of intubation in the Boston City Hospital, in all of which the relief from dyspnoea was immediate. In three cases the tubes were coughed up and swallowed. The recoveries were two.

Dr. DELAVAN called attention to the advantage of feeding by a small cesophageal tube.

Dr. ASCH thought that it was difficult to relieve the pushing downwards of false membrane even by tracheotomy, and that the difficulty of removing the tubes by the general practitioner should be fully considered.

Dr. J. SOLIS-COHEN thought it important to have the patient watched by a skilful attendant after intubation, and the difficulty of giving the patient fluids should not be lost sight of, and suggested



feeding by the nasal catheter. As to the new instruments of Dr. Sajous, he withheld any opinion until it was found that the application to the living subject was found to be practicable.

Dr. CHAPMAN suggested the relief of thirst by giving rectal injections of fluid, and the administration of mercury by inunction.

Dr. WESTBROOK thought that if a thread or wire could be attached to the tube to facilitate its removal by the inexperienced it would be an advantage. The difficulty in swallowing was probably due to the rigid tube keeping the larynx open.

Dr. INGALS, in reply to Dr. Cohen, said that the accident of clogging of the tube and choking was so rare that the possibility of such an occurrence did not trouble him. If it became clogged, it was almost sure to become coughed up if of proper size. A wire or thread attached to it caused too much irritation.

3. *A Modified Laryngectomy.* By Dr. J. SOLIS-COHEN (see p. 349).

4. *The Pathological Nasal Reflex.* By Dr. J. N. MACKENZIE (see p. 373).

5. *Hay Fever.* By Dr. J. N. ROE (see p. 373).

In the discussion which followed the reading of this paper,

Dr. SAJOUS stated that superficial organic alteration was only of temporary benefit, a number of patients so treated having returned to him for treatment. With deep cauterizations he has had universal success.

Dr. MACKENZIE regarded the disease as a neurosis, and had achieved better results when treating it in this manner than by local interference; when the latter was necessary, incisions into the tissue were preferable to destruction or removal. The existence of a nasal lesion is not constant, and is often secondary or accidental. The class of cases in which relief or cure may be expected from local treatment alone is that in which the respiratory membrane is the primary seat of the disease, and in which the nervous system is not decidedly involved. This is the stage in which occur a number of simple reflex neuroses, and which may be cured by local treatment—*e.g.*, removal of a polyp, &c. Even at a later stage, when the symptoms of "hay fever" come on it is possible to secure physiological rest for the new centres, and give temporary and even permanent relief. But when the central nervous system becomes more profoundly impressed, and nearly every organ of the body is included in the arc of the neuro-vascular disturbance, and structural changes occur in different parts of the respiratory and other systems, cure is not to be expected from local measures alone. There is a class of cases in which the cautery and other local measures are entirely

unnecessary, in which there is no well-defined nasal disease. As to extirpation of the cavernous bodies, the total extirpation is an impossibility, and even if practicable would only be warrantable as a last desperate resource. A stellate incision with the cautery knife should be made through cavernous body in the area of most pronounced vascular disturbance. The speaker thinks that all portions of the nasal mucosa may be the starting point of reflexes, but the most sensitive zone is the post end of the inferior turbinated body, and the portion of the septum immediately opposite.

Dr. KNIGHT thought that a proper question would be that of diversion of the nerve influence as exerting influence over the asthmatic attacks. He spoke of cures by the so-called "mind-cure," of which he had seen examples, in which through the influence of mental diversion the attacks of hay fever have been ameliorated or entirely forgotten.

Dr. EDGAR HOLDEN considered it to be a neurosis.

Dr. F. H. HOOPER regarded it as a neurosis, and said that local treatment did much good, especially in children. He preferred chromic acid with general tonic treatment, and doubted if a permanent cure was ever effected of the cases which come on late in the season, but treatment of the mild and early manifestations of the disease is very satisfactory.

Dr. J. SOLIS-COHEN believed the disease to be more constitutional than local, and Dr. Mackenzie's views were correct. In addition to the neurotic element, high living had much to do with it.

Dr. GLASGOW had cured cases by making applications to the larynx alone, and believed that the mucous membrane of the entire respiratory tract should be considered. He did not believe that hay fever is ever cured by local applications. The disease recurs, and the treatment should be constitutional.

Dr. ROE contended that Dr. Mackenzie was too sweeping in his statement, that all reflected nasal disorders are hay fever. He could not regard the latter as a neurosis, although a neurotic subject may be more susceptible to the local irritation which may cause hay fever.

6. *The Treatment of Atrophic Rhinitis by Applications of the Galvanic Current*, by Dr. BRYSON DELAVAN (see p. 372).

Dr. T. A. DE BLOIS applied this treatment to two cases, one of atrophic and the other of hypertrophic rhinitis, the applications being made three times a week for six months. Both cases were improved.

Dr. KNIGHT had found plugging the nose with absorbent cotton applied to one side at a time, and allowed to remain three hours

during the morning, produce great relief. It was then removed, and the other side plugged for three hours in the afternoon. The bad odour is lessened.

Dr. ROE had used the plugs, but the only effect was to set up irritation. He had found great benefit from the application of a weak solution of nitrate of silver (5-10 gr. ad ʒj.), the parts having been previously cleansed. This, applied every other day, almost entirely relieved the symptoms.

Dr. SAJOUS remarked that the good effect obtained by Dr. Delavan was probably due to the irritating effect of the negative pole. He had in two cases obtained absolute relief by the application of chromic acid solution, made by simply allowing the acid to absorb moisture from the air.

7. *Myalgia of the Pharynx and Larynx*, by Dr. S. H. CHAPMAN (see p. 381).

8. *Sensory Affections of the Throat*, by Dr. F. J. KNIGHT (see p. 369).

Dr. JARVIS recently saw a man complaining of pain on either side of the tongue which had existed for two years. He had syphilis, and along with the neuralgia of the tongue, frontal neuralgia and pains in other parts of the body. The speaker had another patient who consults him every five or six months on account of a severe pain in the right anterior pillar of the fauces, which disappears for a week at a time and then returns. The trouble is probably psychical.

Dr. SAJOUS had seen two or three such cases. In one there was follicular pharyngitis, and the pain remained after cure of the pathological condition. The pain seemed worse in damp weather. The history of the case indicated rheumatic trouble.

Dr. GLASGOW had seen many such cases, some being due to gout and others to malaria; sometimes the trouble is kept up by a single hyperæsthetic follicle. In the rheumatic cases there is usually exacerbation at night. These affections in some cases appear to have a tendency to the induction of melancholia.

Dr. MACKENZIE insisted on constitutional treatment.

9.—*Further Researches upon the Function of the Recurrent Laryngeal Nerve*, by Dr. F. DONALDSON, jun. (see p. 375).

10.—*The Anatomy and Physiology of the Recurrent Laryngeal Nerve*, by Dr. F. H. HOOPER (see p. 375).

In the discussion on these two papers,

Dr. F. J. KNIGHT said he had seen Dr. Hooper's experiments. In one case there was inability to get the ether effect, attributed by Hooper to the age and size of the dog. He admitted that it was not quite constant, though generally obtained. He had seen an

experiment in which large doses of morphine caused dilatation, and others in which smaller doses of morphine failed to produce any dilatation. He had seen cases in which chloral certainly did not produce it, but in one case it caused a mixed movement. In a large number of cases he had failed to see preliminary dilatation. Although the operation was done expeditiously, there was closure in all these cases. Certainly the fact remained that dilatation appeared to result, in Hooper's experiments, only from etherization and profound morphine narcosis.

Dr. J. W. LANGMAID had seen most of the experiments related by Dr. Knight, and corroborated what he had said. He had seen Dr. Hooper try to get Dr. Donaldson's results. He had seen one very interesting case. The dog was trephined, a plug inserted, and pressure made on the cortex. This was the only case in which he had seen what he supposed was related by Dr. Donaldson. There was marked dilatation.

Dr. J. H. HARTMANN, having seen Dr. Donaldson's experiments, confirmed his statements.

Dr. J. N. MACKENZIE had observed one experiment by Dr. Donaldson, in which the movements described by Dr. Donaldson occurred in a most marked manner under the influence of morphine. When ether was given the results were more pronounced.

Dr. M. ALLEN STARR said that when in Paris he witnessed some experiments upon hypnotized subjects by Charcot, and in one case, when he made slight percussion just below the larynx, there occurred at once adduction of the vocal cords, causing considerable difficulty in breathing. The case showed that slight mechanical stimulation of the recurrent laryngeal nerve in the human subject would produce adduction of the vocal cords.

Dr. B. F. WESTBROOK said that the pneumogastric was a very complex nerve, representing, at least, eleven nerves. In the laryngeal motor branches there was this distinction, that the sphincters of the larynx, guarding the entrance to the lower respiratory tract during swallowing, were under peripheral control, whereas the abductors acted, not through reflexes from the larynx itself, but automatically through the influence of a centre in the medulla oblongata itself, and was thus under central control. This centre stood as a guard to keep the glottis open, and allow of passage of air into the lungs throughout the entire life of the individual. The partial closure of the glottis during expiration was not active, or only so to a slight extent, whereas opening was an active process, and its great importance was shown by the fact that the vast majority of animals died with the glottis open.

Dr. DONALDSON said that after all this discussion the points he had made last year still stood, and his "inaccuracies" were not proved. Dr. Hooper positively denied that abduction could be obtained without ether, but in his present paper admitted that he obtained abduction under morphine, and in one case (seen by Dr. Langmaid) he got abduction without any narcotic. Dr. Knight had seen dilatation without ether, and Dr. Solis-Cohen had seen dilatation without ether in Dr. Hooper's laboratory. The truth was that the results of any given number of Dr. Hooper's experiments differed widely. In the speaker's experiments there had, however, never been any variation from first to last—viz., weak stimuli universally producing abduction, strong producing adduction. The fact that Dr. Hooper could not obtain exactly the same results proved nothing; it was purely negative.

Dr. HOOPER replied that it was evident that Dr. Donaldson had misconceived the import and significance of the speaker's experiments. He had not meant to imply that Dr. Donaldson's statement that feeble stimuli produced abduction of the vocal bands was inaccurate, although he had never seen such an effect, unless ether had been administered to the dog. When last year he had used the word "consciousness" as a factor in the production of the "ether effect," it would have been better if he had said "narcosis." The statement of Dr. Donaldson that feeble stimuli applied to the recurrent nerves of unnarcotized dogs produced dilatation of the glottis was the point which needed confirmation. The speaker, along with Dr. Bowditch, had failed to get the effect, and had recently devoted seven dogs to this purpose, experimenting according to the method of Dr. Donaldson. They, however, obtained only their usual results—viz., first vibratory movements, then closure. In the seventh dog they had for the first time observed dilatation with feeble stimuli, and they were inclined to regard it as a very rare exception. Dr. Edward Martin had communicated to him results of experiments which accorded with theirs as to stimulation of the recurrent laryngeal nerves.

II. *Measures for the Relief of Congestive Headaches*, by Dr. W. C. GLASGOW (see p. 372).

In the discussion following,

Dr. J. N. MACKENZIE was pleased to hear that his view that the cavernous bodies were congested at the catamenial periods was confirmed by Dr. Glasgow's observations, and affirmed the good results of incision in acute coryza.

Dr. C. C. RICE said his experience had differed from Dr. Glas-



gow's. He regarded the cause as hypertrophic changes of the middle turbinateds, producing pressure against the septum, simply irritative contact with reflex pains. Congestion was not marked. His treatment had been mainly by the use of the galvano-cautery, and he had not found it necessary to draw blood.

Dr. H. ALLEN thought these cases due to pressure effects caused by deflected septum, and contact with the middle turbinated body. He agreed with Dr. Rice.

Dr. SAJOUS partially agreed with the last speaker, but thought that headaches originating in the nasal cavity were due to hyperæsthesia of the mucous membrane, which is overcome by cauterizing the mucous membrane.

Dr. BOSWORTH questioned seriously that the point of contact of the mucous membrane in the nasal cavity was a pathological condition. He had never seen any symptoms arise from the condition.

Dr. ALLEN insisted that contact between parts was injurious, and, as destroying the function of the nose by occluding it, must be overcome.

Dr. GLASGOW contested that it was congestion, not hypertrophy nor hyperæsthesia, that formed the basis of his paper, and the condition of the cavernous bodies was sufficient evidence of this congestion.

12. *Leucoplakia Buccalis*, by Dr. GLASGOW (read by title).

13. *The Treatment of Laryngitis in Professionals who are unable to rest*, by Dr. J. SOLIS-COHEN (see p. 378).

Dr. DE BLOIS found that rest was essential to recovery, and if able to spare twelve hours, excellent results would follow the use of nitrate of silver, but disastrous results followed the use of cocaine.

Dr. BEVERLEY ROBINSON thought that so far as acute cases were concerned there were milder methods than emetics. He uses chloride of ammonium tablets internally repeated every fifteen or twenty minutes, and local applications of carbolyzed spray, modified Dobell's solution, two, three, or four times a day. In chronic forms, internal remedies were of no benefit, but he uses tincture of iron and glycerine locally, and finds benefit from the application of the faradic current two, three, or four times daily.

Dr. BOSWORTH did not believe there was any such thing as laryngitis. The seat of the disease was in the nasal passages. He eliminated the cold in the head by cocaine, and thinned the membrane down with chromic acid. The disease in the larynx would then take care of itself. The cocaine was applied every hour or two hours, dissolved in cosmoline (12 grains cocaine, cosmoline

q.s., to dissolve it) by hand-atomizer, and also inhaled by the mouth. He had not seen any reaction from cocaine.

Dr. ROBINSON stated that Dr. Bosworth's opinions as to cocaine were incorrect, and also that laryngitis does occur independently of nasal troubles.

Dr. SAJOURS most emphatically stated that cocaine in the larynx was pernicious. Sprays being rather irritating in these cases, he administered quinine (one grain) with nux vomica ( $\frac{1}{4}$  grain) internally, every two hours. The faradic current externally, and coca wine internally, were beneficial.

Dr. GLASGOW, in acute cases, where the person *must* perform, applied carbolyzed iodine to the larynx, and thus relieved the congestion, and gave power to the vocal cords.

Dr. RICE thought well of cocaine and cosmoline, but believed that it was the latter which did the work. He had better results with vaseline than with astringents.

Dr. ASCH found muriate of ammonia one of the most useful internal remedies. This, with soothing inhalations and ordinary remedies (excepting emetics), gave speedy relief.

In chronic cases local remedies must be used, and astringents, especially perchloride of iron (gr. xxx.—lx., water  $\bar{3}j.$ ), applied by brush, were the best. In most opera singers some hepatic disturbance required treatment.

Dr. HOOPER spoke of a class of cases in which the voice was altered simply from over-exertion, causing a want of tension in one vocal cord. Electricity externally, and sal volatile internally, gave excellent results.

Dr. MACKENZIE thought that most cases of laryngitis were dependent on nasal disease. He cautioned against the use of cocaine to the larynx and nose. He never used it just before the person was to go on the stage. It was second only to hanging.

Dr. WESTBROOK spoke of derangements of the digestive organs which predisposed to these conditions. He advised emetics, or calomel or jalap, followed by the mineral acids, but did not advise cocaine.

Dr. LANGMAID thought that with so many remedies recommended as very excellent, it should be easy for anyone to cure this class of patients; but as regarded himself, he had found them very difficult to cure.

14. *Glandular and Connective Tissue Hypertrophies of the Lateral Walls of the Pharynx*, by Dr. C. C. RICE. (See p. 368.)

15. *The Galvano-cautery in the Treatment of Hypertrophied Tonsils*, by Dr. C. H. KNIGHT. (See p. 367.)

Dr. SAJOUS had used galvano-puncture, but found it tedious. He modified it by introducing chromic acid after the puncture. The use of the snare is an excellent method.

Dr. MACCOY in the glandular enlargements used puncture, but not in the interstitial hypertrophies, since in these cases cicatrices occur which are apt to give trouble. He was not satisfied that puncture was better than chromic acid passed into a crypt.

Dr. ROBINSON remarked that nothing was so unpleasant as to have to remove large tonsils from a small child. The galvano-cautery is one of the best methods.

Dr. RICE said that very little can be accomplished with the galvano-cautery in the large white tonsils of children, but in adults it is a most useful measure.

Dr. INGALS had used the cautery, but soreness and pain followed its use. In children he is in the habit of etherizing the patient and removing the tonsil with a snare.

Dr. ALLEN thought that while it may be proper to do the cutting operation in certain cases selected with great care, it is wrong to make broad statements. The number of cases in which serious hæmorrhage occurs is larger than is supposed. All the disastrous cases are not reported. Other measures should be used first, and the knife resorted to last.

Dr. DELAVAN thought that when tonsillotomy is done with proper care, with suitable styptics at hand, there is not much danger from hæmorrhage.

Dr. ASCH said that a short time ago one of his assistants removed a small section of a tonsil. The next day there was serious hæmorrhage, and it was necessary to keep up pressure on the tonsil for six hours before it was controlled. In another case he knew of, it was necessary to tie the common carotid artery.

Dr. COHEN thought a great deal of the trouble in tonsillotomy was due to adhesion of the anterior fold of the palate to the tonsil. It has been his custom to free the tonsil first from the palate. In many cases the tonsil will disappear without any treatment whatever. He thought that hæmorrhage came from cutting this fold. He had never had much success with the cautery. It required from twenty to fifty sittings. His plan was to cut into the tonsil transversely, to cut into it the other way, and remove a portion. By making the application every day or every other day, the tonsil is removed in a month or six weeks.

16. *Note on a Frequent Cause of Nasal Hæmorrhage*, by Dr. BEVERLEY ROBINSON. (See p. 373.)
17. *Constitutional Causes of Throat Affections*, by Dr. LANGMAID. (See p. 370.)

In the discussion following the reading of this valuable paper,

Dr. GLASGOW regarded the statement of Dr. Daly that the laryngeal physician should become a laryngeal surgeon as one tending to do much harm, and it had done much to retard progress in this department of medicine.

Dr. SOLIS-COHEN seconded this statement, and said that if he could have his way the paper should be *printed in Capitals*. Many so-called rheumatic pains are really due to the galvano-cautery treatment. He gives his patients guaiacum and purgatives.

Dr. ASCH and Dr. DELAVAN added hearty and forcible commendations of Dr. Langmaid's paper.

18. *A Case of Stenosis of the Larynx*, by Dr. M. J. ASCH. (See p. 379.)

In the discussion, Dr. SOLIS-COHEN said he had not the courage to dilate without preliminary tracheotomy. It was better to perform this first, and then pursue active measures for the relief of stenosis.

Dr. KNIGHT stated that Schroetter's method had been very slowly popularized in America.

Dr. MORGAN related a case in which he used dilators without permanent benefit, but kept the disease in abeyance by constitutional and local treatment. The patient would not consent to tracheotomy, and died suddenly of laryngeal spasm.

Dr. DELAVAN thought O'Dwyer's intubation method would modify the present methods of treatment by dilatation.

Dr. ASCH thought that by O'Dwyer's method an advantage was gained in that tracheotomy was rendered unnecessary.

19. *On the Etiology of Deflections of the Nasal Septum*, by Dr. BRYSON DELAVAN.

Dr. MORGAN traced his cases to traumatism almost invariably. He had seen but few cases in the African.

Dr. DONALDSON thought it was less frequent in the African than the white.

Dr. SOLIS-COHEN had noted the concurrence of high arched palate and deflected septum, but the one condition often occurred independently of the other. Many children under seven years of age have deflected septum. It was difficult to properly estimate traumatism and racial peculiarities.

Dr. SAJOUS thought that traumatism as a cause could not be clearly defined.

Dr. MACKENZIE regarded traumatism as the most common cause.

He had not seen a case in an African requiring operation, and had been astonished at the brilliant results claimed for some operations.

Dr. DE BLOIS had examined the noses of several pugilists which had been flattened and bruised severely and repeatedly, and had been surprised to find the septum in the correct line. These cases could properly be called traumatic.

Dr. ROE described several varieties of deflected septum, and particularly objected to the use of the punch in treatment.

Dr. INGALS had seen deflected septum in children two years of age, and had arrived at the conclusion that unless the nasal bones were fractured, or the cartilages dislocated, traumatism was not likely to cause deflected septum.

20. *The Notes of a Case in which a pin had been removed from the Larynx, where it had remained for two years*, sticking through the ventricular band, were presented by Dr. LANGMAID.
21. *A Muscle Extending from the Opening of the Eustachian Tube, across upon each side*, was described by Dr. J. SOLIS-COHEN.
22. *A Case of Recurrent Naso-Pharyngeal Tumour*, by Dr. RUFUS P. LINCOLN (see p. 374).
23. *Two Cases of Congenital Occlusion of the Anterior Nares* were described by Dr. W. C. JARVIS (see p. 372).
24. *A Comparative Study of some of the Methods of Treatment best adapted to the Relief of Occlusion of the Posterior Nares due to Hypertrophy of Soft Parts*, by Dr. A. MACCOY (see p. 372).

In the discussion following,

Dr. JARVIS spoke of the use of his transfixion needle. He never used cocaine as a preliminary, but included the hypertrophy within the loop, tightened the wire, and then applied cocaine. Chromic acid is regarded by him as dangerous, and he never removes a hypertrophy by the galvano-cautery.

Dr. RICE had given up using transfixion needles, and had never seen any bad effects from the use of chromic acid.

Dr. DONALDSON, jun., favoured the use of chromic acid. Profuse hæmorrhage may follow the use of transfixion needles.

Dr. DELAVAN had finally discarded chromic acid. No case of hæmorrhage had occurred to him where it could not be easily controlled.

Dr. JARVIS said that to attempt to remove a posterior hypertrophy, while deflection of the septum existed, was very poor surgery. The removal of the deflected septum will cause the disappearance of the posterior hypertrophy. It is trifling with a patient's nostrils to use chromic acid, when the hypertrophied tissue can be so readily removed with the transfixion needles.



Dr. MACCOY said that with his instrument, a single application of chromic acid was sufficient, and the use of the needle was difficult.

Dr. JARVIS remarked that the fault of the needle was in the operator and not the needle.

The following papers were read by title.

25. *Affections of the Crico-Arytenoid Articulation*, by Dr. G. W. MAJOR. (See p. 380.)
26. *Cancer of the Larynx*, by Dr. H. A. JOHNSON. (See p. 381.)
27. *A Case of Recurring Laryngitis Hæmorrhagica*, by Dr. C. E. BEAN. (See p. 379.)
28. *Plaster of Paris Dressing for Fracture of the Nose*, by Dr. J. W. ROBERTSON.

Dr. DE BLOIS exhibited a plaster of Paris splint for nasal fracture.

Dr. JARVIS explained his external splint, for application after operation on the cartilages and bones, in certain cases of deflected septum, or for fracture.

Dr. ROE exhibited a nasal saw operated on by an electro-motor.

Dr. DE BLOIS exhibited a bag with a compartment containing a band and compression gauge.

Dr. MORGAN exhibited a universal powder blower, and also a modification of his uvula hæmostatic clamp.

Dr. ALLEN exhibited a laryngeal snare which worked on the lever principle.

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The following was elected *Honorary Fellow* :—

Dr. A. JACOBI, New York.

The Association then adjourned.

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**BALNEO-THERAPEUTICS IN THROAT  
DISEASE.**

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THOSE who dwell in great cities and to whom the solar rays are vouchsafed "as through a glass darkly," and who are also victims of the many ills that flesh is heir to, will ponder with due satisfaction over the ancient saying of Pliny, "Sol est remediorum maximum." A great mass of sufferers from ills real and imaginary, migrate from these islands annually, to scatter themselves about the various "health resorts," "spas" and "cures" of Europe. With those restless individuals in search of pleasure we have nothing to do ; but, considering the great lack of knowledge there is concerning the therapeutic value of baths and mineral waters, we propose to give a short account of those waters and wells most suitable for the treatment of the class of complaints of the upper respiratory passages which we are most commonly called upon to deal with. We do this partly because there is a real benefit to be derived from judicious therapeusis of this nature, and partly because in an age when medical methods are tending to much more scientific modes of application, the balneo-therapeutical and climatic treatment of this class of disorders is by no means one of the least successful. Furthermore, there is an unfortunate tendency to ignore many general underlying conditions of the organism, and to become too surgical in the treatment of throat diseases. The pendulum of specialism is apt to swing too far, and we observe this tendency with some concern. No local treatment, however brilliant, can hope to be successful unless it takes into account the general underlying condition of which this local effect is often the outward and visible manifestation ; and this statement is particularly true as regards the various affections of the upper respiratory passages. It is not possible to believe all the statements of balneologists ; interest, enthusiasm, unscientific observations, and untenable conclusions have been answerable for bringing their science into some disrepute. Stripped of all their extravagant laudations, of this, that, or the other spa, well, or "cure," there is a solid residuum of fact, which none can

controvert, and that is that the therapeusis of mineral waters and climatology deserves much more careful recognition at the hands of those called upon to treat the affections of the "upper respiratory passages." It is usual to attribute to the climatic surroundings much of the good effect observed, and this is undoubtedly true, more or less, in all cases, and is perhaps the only recommendation of certain mineral springs. As Dr. Constantine James remarks wisely, in speaking of the cure of rheumatism, "So many springs, so many specifics. Unhappily, when one comes to examine, not only the prospectus, but the patients themselves, one is too often convinced that any success obtained is derived from the fact that these patients have undertaken the 'cure' precisely at that period when their pains are least likely to manifest themselves, viz., the summer; but when the first colds of winter arrive, how many relapses, and how many deceptions are experienced? Not that one should refuse any curative action to mineral waters. On the contrary, this is very great; but the 'cures' will be more frequent and more lasting if instead of sending indiscriminately to the same baths a crowd of vague disorders, included under the general name of 'rheumatism,' the choice of a water was decided upon only after a careful study of the divers factors giving an individuality to each sufferer; and the appropriation of these characters to the single activity of each spring to which one may look for the key of thermal medication."

It may safely be said, that most throat affections owe their presence to some constitutional condition, be this, gout rheumatism, phthisis, scrofula, catarrhal tendencies, gastro-intestinal and hepatic, cardiac or pulmonary states, errors of living, diet, or surroundings, or special predisposition, which only means that a particular mucous or other tissue has less power of resistance to the inroads of disease, or suffers a physiological perversion, which amounts to a pathological condition. Consequently in treating throat diseases the more physician, and the less surgeon, the practitioner, the more successful will he be, and the more truly scientific will be his methods, which will be directed, not to removal and absolute destruction of function, but to repair, and correction of perverted physiology. Not that we mean to imply that the throat practitioner must not often be surgical; but he requires to be a good physician as well.

The European mineral waters may be roughly classified as—

1. The sulphurous, containing free  $H_2S$ , and combinations of sodium and calcic sulphides.
2. The saline, characterised chiefly by the presence of sulphates and chlorides.



3. The alkaline, chiefly containing carbonates of soda, lime, and magnesia, sulphates, chlorides, and alkaline silicates.

4. The ferruginous : iron, held in solution by carbonic and sulphuric acids.

5. The iodo-bromated, in which small quantities of iodine play the chief part.

6. The gaseous, in which carbonic acid predominates.

Of these, the sulphur and the salt springs are those most likely to be of service in the treatment of throat complaints, and we shall only refer to these.

SULPHUR SPRINGS.—We are not quite sure of the therapeutical rationale of sulphur applied to mucous membranes, but there is no doubt that it is eminently serviceable. Sulphur springs on the Continent are either of (1) the stimulant order—such are the waters of Eaux Bonnes, Barèges, Aix-les-Bains and Luchon, Cauterets, Vernet, Labasserre, St. Honoré, Enghein, Pierrefonds, and Amélie-les-Bains ; or (2) of a sedative order, such as Weilbach, Allevard, Caille, Marlioz.

France thus possesses a great number and variety of sulphur springs. Weilbach, Aix-la-Chapelle, Soden, Schinznach, Baden, Eilsen, Neundorf, Langenbrucken, are the only German springs worth comparison. Of these, Barèges, Eaux-Bonnes, Luchon, Cauterets, Penticouse, Ax, and Amélie, are situated at high altitudes in the Pyrenees, varying from 680 to nearly 6,000 feet, and climatic considerations have to be taken into account in determining their respective values. The German sulphur baths are none of them situated over about 1,000 feet high. Sulphur is administered by baths, or the so-called piscine baths (*i.e.*, baths in which several persons can swim or move about) and by internal medication. It is sometimes desired to get the effect of inhalation of the fumes of sulphuretted hydrogen into the lungs. The general effect of sulphur baths may be summed up as follows :—

1. The small amount of sulphurets is of no consequence, since it is not proved that they are absorbed in bathing. 2. The amount of sulphuretted hydrogen is very slight in most baths, and it is doubtful if it is absorbed. 3. It is also doubtful if sulphur baths have any action other than that of perfectly indifferent thermæ.<sup>1</sup>

The beneficial effects of these sulphur baths are probably as much due to the effect of the warm water and the high altitude of the health resort as to the sulphur. Not so, however, in the drinking of sulphur waters.

We do not dwell upon inhalation of sulphuretted hydrogen, as practised at some springs, since it is almost certain that the gas

<sup>1</sup> Braun : *Curative Effects of Baths and Waters.*



inhaled in this manner is as quickly exhaled, and does not really enter into combination with the blood. It is, however, different with sulphur waters when taken internally into the stomach. This mode of administering them ensures their passage into the portal vein and entry into the venous pulmonary system. From the destruction of red corpuscles caused by sulphur waters, and the consequent anæmia, this mode of medication should be supplemented by copious meat diet. The treatment is eminently fitted for reduction of hepatic engorgements and congestive conditions of the gastrointestinal tracts, and also for catarrhal conditions of mucous membranes, particularly the respiratory. This property has been much made use of lately in the medication of pulmonary phthisis (see article in this Journal, No. 7, 1887) by rectal injections, and at the present time, though much has been written upon the subject since that article appeared, we are enabled to say that, divested of all sensational and enthusiastic laudations on the one hand, or hasty and pessimistic condemnations on the other hand, the method of internal medication by sulphurous waters is undoubtedly serviceable in certain pulmonary states, not only phthisis, but passive engorgements accompanying emphysema, bronchitis, and asthma, and this beneficial result is not wholly due to the climatic and hygienic surroundings of a watering place, since it can be obtained in the heart of a great city by employing the imported mineral waters. It is probable that at some of the foreign spas, such as Aix-la-Chapelle, the beneficial results attributed to sulphur are as much due to chloride of sodium as to the sulphur.

The class of cases benefited by treatment by the sulphurous waters are essentially those of the respiratory tract, whether due to passive congestions, or of low inflammatory or purulent type. Thus chronic laryngitis, pharyngeal, post-nasal and bronchial catarrhs, incipient phthisis, of the apyretic type, are relieved by this treatment. The so-called "clergyman's sore throat," though benefited by sulphur treatment, is perhaps more amenable to the alkaline waters rich in chlorides. Sulphur waters are used in spray form very frequently, and many of the French spas contain extensive apparatus for this kind of treatment. Ozæna and pharyngeal catarrhs, especially in the scrofulous, are particularly well suited to this medication.

SALT SPRINGS.—The mineral waters rich in chlorides are perhaps the most generally serviceable in pulmonary and throat complaints. Common salt waters are applied either in the form of "sool-baths" (or "brine baths"), or administered internally. Of the latter we will speak first. The chief springs in Germany are Soden, Kronthal,

Baden-Baden, Canstatt, Wiesbaden, Kissingen, Homburg, Kreuznach. French saline springs are Aix, Royat, Mont-Dore, Bride-les-Bains, Salins, Vittel, Bourbonne, Néris, Bains. The waters of Royat contain a large proportion of alkaline carbonates, and chloride of sodium, traces of arsenic and free CO<sub>2</sub>, and a little iron. They are eminently suited for the treatment of asthma and various catarrhal throat and pulmonary complaints, and the high altitude and charming scenery and climate have contributed to make it one of the most favourite of health resorts. The waters of Mont-Dore, which, like those of Royat, are taken hot, are also exceptionally good in the treatment of laryngeal and bronchial catarrhs, chronic coryzas, granular sore throats, and chronic tonsillar complaints. Extensive establishments exist for baths and pulverizations and inhalations.

Most of the German saline springs are situated on the range of the Taunus Hills. Of these, unquestionably one of the very best is Soden. Containing, as it does, some twenty-three springs with a temperature varying between 12° to 18° C., and with one thermal spring of temperature of 30° C., the waters of which are charged with chloride of sodium in varying degrees up to 116 grammes per litre, and some of which are further charged with carbonic acid (notably the Champagnerbrunn), the health resort of Soden is, though at the present one of the less known of the German spas, unquestionably one of the very best places for the treatment of pulmonary and catarrhal complaints. Additional advantages are the complete protection of the village from north winds, the comparatively high altitude and equable climate, which make it of all others in Germany, the resort most suitable for the treatment of phthisis, either of the throat or lungs, and catarrhal conditions generally. No spa possesses the peculiar and distinctive advantages of Soden. Though a small amount of iron is present in the waters, they are not on that account contraindicated in the treatment of incipient phthisis.

Compressed pastilles of Soden water are now an article of commerce, as well as the mineral waters. These are made from two of the well-waters, and containing a large amount of chloride of sodium, are particularly serviceable in pharyngeal catarrhs, and may even in some degree be used where it is desired to obtain the effect of the Soden treatment in persons who are unable to make the necessary journey to the spa itself.

The inhalation and vaporization treatment to be obtained at Homburg, the waters of which place contain much sodium chloride, is well adapted for chronic laryngeal and pharyngeal conditions. The waters of Wiesbaden, though warm, are very deficient in sodic chloride,

Rémé in Westphalia contains a hot spring ( $31^{\circ}$  C.), of which chloride of sodium is a prominent constituent, the waters of which are extensively used as inhalations for pulmonary complaints.

The waters of Kreuznach are strongly impregnated with chloride of sodium, and approach nearly to those of Soden, Homburg, and Nauheim. Containing iodine and bromide of soda, they are largely prescribed for lymphatic and scrofulous affections.

Speaking generally of the health resorts where sodium chloride forms an essential feature of the treatment, that is in pulmonary and throat troubles, incipient phthisis, laryngitis, granular pharyngitis, bronchial catarrhs, &c., Soden, Royat, and Mont-Dore are the places to be preferred. As to the action of sodium chloride on the economy, it is certainly very stimulant. Absorbed into the blood, and excreted by the various epithelial structures, it increases the physiological activity of these tissues, and at the same time modifies their secretions profoundly, both as regards their nature, composition, and reaction. Improving the nutrition of mucous membranes, and stimulating the vascular absorption, it thus comes to modify their mucoid or purulent secretions, quickening both retrogressive and formative processes, and its great value as an expectorant in chronic catarrhs of the pulmonary mucous membrane must be explained on these grounds. All these effects are increased both by the presence of carbonic acid and the warmth of the water, and a smaller quantity of such waters is therefore required to produce a physiological effect. Chloride of sodium waters, such as Soden, which may be taken as the type, are therefore indicated in all throat conditions when a local and general stimulant and metabolic action is desired in preference to sulphur waters, which modify purulent catarrhal conditions more particularly.

As to the use of "sool" or "brine" baths, little that is of real value is known. Knowing how little absorption takes place through the skin, it is doubtful how much their effect is due merely to the influence of warm water, whether or not in motion. Waters which contain carbonic acid owe part of their properties to the absorption of this body through the skin, and narcotism has even been known to occur. Sool baths resemble sea baths remarkably in their mode of action. They are stimulating and promote nutrition to the skin, and tissue change, and possibly a small quantity of the salt is absorbed. While the weaker sool baths (2 to 3 per cent. Na Cl) may be regarded as the sufficient average strength, much less than this suffices for some patients, and stronger sool baths are undoubtedly irritating. It matters much less which health resort be chosen, so far as regards the actual bath, than that the baths be given of a strength suited to the

individual case. Sool baths produce their stimulating action at a lower temperature than would simple warm water. As far as throat and pulmonary complaints are concerned, they may sometimes be combined with a course of waters, but great care should be exercised in discriminating the class of cases to which they are applicable. The simple catarrhs, rheumatic and scrofulous conditions are probably those best adapted for this method.

As for the baths and waters of the ferruginous and alkaline order, we do not perhaps need to say much. Of the latter, Ems is perhaps the most generally serviceable in pulmonary and throat complaints. Neuenahr, Vichy, and Mont-Dore are equally well known.

In the treatment of goitre, those waters containing iodine have been specially vaunted, such as Saxon, Challes, Wildeg, Castrocara, and Heilbrunn.

Mineral waters and "spa cures" are not to be left to the patient's choice or discretion. The knowledge of the right spring for any complaint is only to be obtained by a careful study of the disease in question. While experience teaches us that it is not wise to deny the virtues of this method of medication, it also teaches us that it deserves a much more careful study at the hands of the practitioner than it has hitherto received. It would be beyond our scope to go into minute detail, and we have wished only to direct attention to certain considerations and principles.

Over the Kurhaus at Ischl is inscribed in golden letters—

"In sale et in sole omnia consistunt"

(a curious motto for a place which possesses no medicinal springs of its own); but we may safely say that most, if not all, of the benefits to be derived from a course of mineral waters in throat complaints are to be found in "salt, sun, and sulphur."

We may at some future time return to this subject of Balneotherapy.

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## NEW INSTRUMENTS AND THERAPEUTICS.

STOERK (Wien).—A New Œsophagoscope. *Wiener Med. Wochenschr.*, No. 34, 1887.

THE new instrument differs from the other well-known instrument of Stoerk by its simplicity. The tube for the œsophagus is not mobile, but fixed at a right angle to the intracœsophageal part. In this manner it is possible to avoid very complicated mechanism, and the instrument is not so dear as the former one. MICHAEL.

**JELENFFY** (Buda-Pest).—A New Fixable Nasal Speculum. *Berl. Klin. Wochenschr.*, No. 30, 1887.

NEW form of nasal speculum which can be fixed either by the hand of the patient himself, or on a frontal band. MICHAEL.

**FRITSCHÉ** (Berlin).—Treatment of Acute Coryza. *Berl. Klin. Wochenschr.*, No. 27, 1887.

FRITSCHÉ recommends the internal use of salicylic acid, and the sniffing of a preparation which he calls "*Olfactorium aceto-carbolicum*," compounded as follows:—

R Acid. acet. glaciale,  
Acid. carbol. ãã 2'0 grammes.  
Mixt. oleosobalsamic, 8'0,,  
Tr. moschi, 1'0 ,,

MICHAEL.

GUY.—The Treatment of Whooping Cough in 1887. *Thèse, Paris*,  
1887.

THE author considers whooping cough to be a malady running a definite course, and without any medical specific capable of arresting the disease at its commencement, or shortening its course. The only means we know of are those to combat the spasmodic element, or modify the catarrhal condition. This must vary as one or the other set of symptoms predominates. In the catarrhal period, emetics and sedatives; in the spasmodic period, bromides, chloral, and belladonna must be relied on. No specific medication can be directed to the parasitic element, but sprays of carbolic acid, or nasal insufflations, may be recommended. These latter act as mechanical and antiseptic agents.

JOAL.

FÜLLGRAFF, O. (New York).—The Importance of Proper Respiration in the Treatment of Non-surgical Diseases of the Larynx, Trachea, and Bronchial Tubes with Medicated Spray, and some Explanations and Suggestions as to the Achievement of Beneficial Results. *N. Y. Med. Times*, April, 1887.

DILATES on the importance of proper respiration and inflation of the chest whilst undergoing the spray treatment. J. N. MACKENZIE.



**SCHOPPE** (Bonn).—**Dietetics of the Voice, Study of the Effect of Massage on the Larynx.** *Bonn*, 1887, 45 pp.

THE little book gives a popular description of the anatomy and physiology of the voice and of the physiological effect of massage, which is recommended as a means of medication for all catarrhal and nervous diseases of the throat.

MICHAEL.

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## DIPHTHERIA.

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**TEISSIER, J.**—**Etiology of Diphtheria: Transmission by Atmospheric Dust.** *Acad. des Sciences*, June 6, 1887.

FOLLOWING upon studies made by the author at Lyons since 1880, upon the propagation of contagious maladies, he has particularly investigated the conditions which lead to diffusion of the diphtheritic germ. He is able to conclude that diphtheria is a specially infectious disease, the germs of which, transmitted by atmospheric dust, are essentially absorbed by the respiratory channels. The dusty emanations from manure heaps, rag and straw depôts, lend themselves particularly to this mode of conveying contagion, and constitute excellent media for the development of this pathogenic germ. Pigeons and poultry seem to be the most effective agents for the spread of the different media of infection. Cold favours the receptivity of the individual.

JOAL.

**THORESEN** (Eidsvold, Norway).—**Experience of, and Critical Remarks upon Diphtheria.** *Norsk Magazin for Laegevidenskaben*, January, 1887.

THE author, who has had ample opportunity of studying diphtheria, has found that the period of incubation of this disease is between a few hours and a few days. He has never seen a person suffer twice from diphtheria, and believes that one attack of the disease confers immunity. The onset of diphtheria with strong initial rigors, vomiting, and debility, and a short period of incubation, must be considered unfavourable. Extensive and thick membranes, especially when spreading over the soft palate and pharynx, and great swellings of the submaxillary glands, especially if on both sides, are unfavourable symptoms. About half of the patients attacked with nasal diphtheria succumb. Adynamic fever, weak action of the heart, difficulty in breathing and vomiting are, as a rule, forerunners of death. In one epidemic which the author observed, several of the patients presented small circumscribed effusions of blood of the size of a pin's head

spread all over the body, and all attacked in this way died. The palsies occurring after slight cases of diphtheria generally offer good prognosis, while palsies after severe cases often end fatally. The author quotes three fatal cases of *paralysis of the pneumogastric nerve* in boys (attacks of suffocation, irregular action of the heart and vomiting), occurring in two cases shortly after the attack of diphtheria, while in the third case the patient was up and apparently convalescent. For treatment, the author recommends hygienic measures and gargles of chlorate of potash.

HOLGER MYGIND.

**KIONIG** (Christiania).—**Diphtheria in a Prison.** *Tidsskrift for praktisk Medicin*, September 1, 1887.

A PRISONER, aged twenty, who had been a year and a half in prison, was attacked severely with diphtheria of the fauces. After the patient had begun to recover, serious paretic symptoms of the throat and gullet supervened, paresis of accommodation, and later on palsies of the muscles of the neck and arms, with subsequent atrophy of the muscles and extreme emaciation. He recovered, however, at last. There was no other case of diphtheria in the prison, and the only probable explanation of the way in which the contagium had reached the patient was that the prisoner had worked in a shed where a man from outside, whose child suffered from diphtheria, had previously been.

HOLGER MYGIND.

**SÜSS.**—**Diphtheritic Paralysis of the Pneumogastric.** *Rev. des Mal. l'Enfance*, June, 1887.

IN convalescence from diphtheria nervous affections of the digestive tract, the lung and heart are sometimes observed, and they may end fatally. They follow other paralyses more or less grave, especially that of the arch of the palate. Though gastric or pulmonary signs may be absent cardiac implications are always present. In chronological order, abdominal signs are the first to be observed, and principally consist of abdominal pains and vomitings, more or less violent. Cardiac signs are always accompanied with a very characteristic sign—pallor of the face and the mucous membranes. Acute pains, resembling angina pectoris, also occur. Pulmonary complications are manifested by dyspnœa, more or less intense. Death is a common termination. The only treatment consists in application of electricity to the cardiac region and thorax. JOAL.

**COUTANCES.**—**Contribution to the Study of Diphtheritic Conjunctivitis.** *Thèse, Paris*, 1887.

DIPHThERIA may manifest itself locally on the conjunctiva just as on

other mucous membranes. Diphtheritic ophthalmia may be met with at all ages; every cause leading to debility, and especially hereditary syphilis, predispose to it. Cold may be regarded as an adjuvant cause, but the ocular affection declares itself especially when the conjunctiva is previously unhealthy, the pathogenic microbe having an action only upon an injured mucous membrane. Diphtheritic conjunctivitis differs essentially from purulent ophthalmia by its general symptoms and also from conjunctival croup. The malignancy of the affection varies much according as the ocular affection is an isolated case, or occurs epidemically. JOAL.

**TORDAY.**—Case of Laryngeal Diphtheria with great Subcutaneous Emphysema. Cure. *Archiv für Kinderheilkunde*, 8 Bd. 6 Heft.

A CASE in which great diphtheritic stenosis existed; tracheotomy was not allowed by the parents. Subcutaneous emphysema resulted, commencing in the back, and spreading in some days over the whole child. It diminished and disappeared entirely within fourteen days. The author believes that it was caused by rupture of an alveolus caused by forced respiration during the stenotic affection. Such cases are rare, and most of them die. MICHAEL.

**FILATOW** (Liban).—On Scarlatinal Diphtheritis. *Archiv für Kinderheilkunde*. Bd. 9, 1 Heft.

THE paper treats of the question if diphtheria so often combined with scarlatina is only a symptom of this disease, or if it is a special disorder. The author believes the former, because it is not probable that a patient would so often acquire two infectious diseases at the same time, but there undoubtedly occurs sometimes a combination of the diseases. MICHAEL.

**SEIFFERT** (Wurzburg).—Croup of the Mucous Membrane of the Nose. *Munchener Med. Wochenschr.*, No. 38, 1887.

COMMUNICATION of three cases.

MICHAEL.

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## TONSILS, PHARYNX, &c.

**COËN** (Wien).—Diseases of the Uvula and their Influence on Voice and Speech. *Wiener Med. Presse*, Nos. 25, 26, 1887.

AN essay on the different idiopathic and symptomatic inflammatory conditions of the uvula, and hypertrophy and atrophy of this organ, in which it is shown how in all these diseases speech can be more or less affected. MICHAEL.

**DOWNIE, J. WALKER** (Glasgow).—**Hæmorrhage following Tonsillotomy.** *Edin. Med. Journ., September, 1887.*

THIS paper embraces the subsequent history of a case bearing the same title which appeared in the *Edin. Med. Journal*, August, 1886, and has been already noted in this Journal (*vide* p. 16). The patient died of hæmorrhagic phthisis. The writer remarks that, in the early stages of the disease, he diagnosed the hæmorrhage as being of pharyngeal origin—"though bright in colour, it was not frothy as in hæmoptysis." . . . "The pharynx, naso-pharynx and larynx were here again carefully examined, and as a considerable proportion of the blood was now expelled through the nose, and as a quantity was lodged in the naso-pharyngeal space, and also as a careful examination of the chest gave negative results, the ruptured vessel was for a time considered to be in that part, which opinion was strengthened by the fact that the bleeding seemed to be at once checked by the insufflation into that space of tannic acid." The author ventures the suggestion that "the profuse hæmorrhage which followed excision of the tonsils twelve months previously, may have in a remote way predisposed the patient to phthisis."

(The author deserves credit for the careful and painstaking manner in which he has followed up and recorded this case. We cannot refrain from remarking, however, that a microscopical examination of the sputum might have been of service in elucidating the true nature of the disease in its early stages. This might have been accomplished during the intervals between the hæmorrhages, for it is useless to search masses of blood for evidences of pulmonary disease. The causal relationship between the tonsillar and the pulmonary bleeding seems somewhat hypothetical; might they not have been due to one and the same cause?)

HUNTER MACKENZIE.

**LABORDERIE, DUBOUSQUET.**—**Clinical Considerations on Infectious Amygdalitis.** *Gaz. des Hôp., September 6, 1887.*

THE present observations tend to confirm the author's views published in 1886 (this Journal, vol. i., p. 60), and also those of Rannenberg, Bouchard, and Landouzy.

JOAL.

**RETHI** (Wien).—**On Neuroses of the Pharynx.** *Internat. Klin. Rundschau*, Nos. 35, 36, 37, 1887.

NEUROSES of sensation are such anomalies of sensibility as exist without local disease, and depend upon central or peripheral reflex causes. By caustic treatment of the most sensitive spot, both peripheral and central neuroses can be cured.

MICHAEL.

**McBRIDE** (Edinburgh).—**The Adenoid Tissue at the Base of the Tongue as a Factor of Throat Symptoms.** *Edin. Med. Journal*, Sept., 1887.

FROM his own observations, and from those of others, the author describes this condition as more often producing symptoms in women, while existing almost as frequently in men; it is more likely to occur after adult life than before it. The symptoms are, the feeling of a foreign body, pain usually localized, but sometimes radiating to other parts, and fatigue in speaking. Occasionally cough and spasm are present. The treatment recommended is to free the epiglottis from the redundant tissue at the base of the tongue, and if necessary destroy the latter by the application of the galvano-cautery, nitrate of silver, or chromic acid.

HUNTER MACKENZIE.

**LANGERHANS** (Berlin).—**Case of Soor of the Œsophagus with Purulent Inflammation of the Mucous Membrane.** *Virchow's Archiv*, Bd. 119, Heft 2.

A PATIENT died from diabetes mellitus, and an unusual development of soor was found in the Œsophagus. The only symptom during life was the circumstance that the patient always had a bad taste during his last days. The mucous membrane was in a state of high inflammation.

MICHAEL.

**SOTA, RAMON DE LA.**—**A Bone arrested at the Level of the Junction of the Superior and Middle Third of the Œsophagus. External Œsophagotomy. Cure.** *Rev. Mens. de Laryngologie*, Sept. 1887.

THE author adds the following reflections on this case:—In the case of a foreign body in the Œsophagus, the manœuvres executed by inexperienced persons are really dangerous. Attempts to remove the foreign body with the fingers may provoke inflammation from injury to the pharyngeal mucous membrane, sufficient to render ulterior operations very difficult. Violent efforts at extraction or propulsion are prejudicial, for the mortality of external Œsophagotomy depends, not upon the operation itself, but upon the lesions produced in the Œsophagus by previous ineffectual attempts to effect extraction.

JOAL.

**FISCHER** (Hanover).—**Œsophagotomy for Foreign Bodies.** *Deutsch. Zeitsch. für Chirurgie*, Heft. 6, 1887.

REVIEW of eighty published cases. The author concludes: Œsophagotomy for foreign bodies is not a very perilous operation. Death after operation is caused much oftener by the foreign body, which had been too long in the Œsophagus, leading to perforation of the



mucous membrane, and consequent pleuritis or septicæmia. The operation, therefore, must be performed as soon as possible if the foreign body cannot be removed *per vias naturales*. This is especially necessary if the body is jagged. MICHAEL.

**POTAIN.**—Syphilitic Contraction of the Œsophagus. *Semaine Méd.*, June 29, 1887.

A LECTURE delivered at the Charité, on a case presenting also paralysis of the motor ocular muscles, generally of syphilitic origin. The professor rejected the idea of congenital or cancerous stenosis. It does not, however, suffice that a patient should have syphilis and œsophageal stricture in order to establish an etiological connection; it is necessary to look for the special characters of specific stenosis. These are not, however, clear, and the diagnosis can only be founded on the absence of evidences of any other cause. When there is neither evidence of cancer nor of mediastinal tumour, when the seat of the stenosis in the œsophagus is other than that favoured by cancer, when the contraction is clearly defined and annular, and when the patient does not present a history of old ulceration of the œsophagus, due to traumatism, then only can one begin to think of syphilis. JOAL.

## NOSE AND NASO-PHARYNX.

**PAULSEN** (Kiel).—On the Glands of the Mucous Membrane of the Nose, especially the Glands of Bowman. *Archiv für mikroskop. Anatomie*, Bd. 26.

THE author has examined the glands of the regio-olfactoria in divers animals, and found that they have a mixed epithelium. These glands not only occur, as some authors maintain, in the region of the olfactory epithelium, but also in the region where ciliated epithelium is found. MICHAEL.

**ENJALRAN.**—Anatomical and Clinical Study of Luschka's Gland. *Thèse*, Paris, 1887.

A THESIS inspired by Dr. Gougenheim, in whose clinic the author has gathered four cases of Tornwaldt's disease. He reproduces the facts observed by Tissier and Luc, studies the etiology, symptomatology, diagnosis and treatment of the affection, without, however, adding any new observation, or relating any original matter. JOAL.

**BISHOP, S. S.** (Chicago).—**Hay Fever.** *Journal of the American Medical Association*, July 23, 1887, also in *Annual Report of United States Hay Fever Association*, for 1887.

At its last meeting, the United States Hay Fever Association offered a prize of 25 dollars for the best essay on Hay Fever, submitted to that body during the year. Two prizes were awarded, the first falling to Dr. Bishop, of Chicago. The author is evidently a close student of recent "hay fever" literature, and advocates, in the main, the theory, first gaining ground in this country, that the affection is a neurosis characterized by excessive irritability of the nerve centres *plus* a hyperæsthetic condition of the mucous membrane of the respiratory passages. The paper adds nothing to that which is already known concerning the disease, and is original only in so far as the author fails to mention the sources from which he obtained the materials for the construction of his essay. JOHN N. MACKENZIE.

**BELL, J. E.** (Overton, Georgia).—**Hay Fever.** *United States Hay Fever Association's Annual Report for 1887.*

THE second prize was awarded to Dr. Bell, of Overton, who attempts to controvert the neurosis theory, and advocates the view that the disease is due to the action of pollen on exposed mucous membranes. His conclusions are as follows :—

1. Hay fever is primarily and *per se* a local trouble, the effect of a specific irritant on certain air-exposed mucous membranes in persons having a peculiar predisposition.

2. This predisposition must be sought for on the *surface* of the affected parts, and is not necessarily pathological.

3. The irritant usually acts by direct contact, though similar symptoms may follow its introduction into the stomach, whence it enters the circulation and impresses the susceptible mucous surfaces by a species of elective affinity.

4. The systemic disturbance is the result of constitutional sympathy with the local mischief.

5. Like quantities and like continued application of the irritant would give rise to the same symptoms in susceptible persons, without regard to time or season.

A believer in the pollen theory, he naturally takes a gloomy view of the prognosis, and holds that the disease is incurable. Among palliative remedies, he strongly recommends the inhalation of the vapour of the oil of peppermint. It is especially serviceable in the unbearable itching of the eyes. The vapour extending over the con-

junctiva and producing a partially anæsthetic, cooling, and stimulating effect, causes profuse lachrymation with cessation of the itching.

JOHN N. MACKENZIE.

**MATHIESEN, C. A.** (Norway).—**A Case of Abundant Watery Discharge from the Nose after a Fall on the Head.** *Norsk Magazin for Lægevidenskaben*, January, 1887.

A LAD, aged thirteen, fell down the hold of a ship and received a small wound of the left temporal region, was unconscious for some time, but could afterwards walk home. During the night vomiting and bleeding from the nose occurred. The next morning he had no recollection of what had happened after falling. Later on the patient felt well, except for having a feeling of heaviness in the head, until eighteen days later, when a watery fluid of salt taste began to be discharged incessantly from the left side of the nose, especially abundant when the patient stooped forward: 25 grammes of the fluid were collected in two hours. After having lasted for a week the discharge stopped, five days later the patient began to vomit, became drowsy, and œdema occurred of the left upper lid and the adjacent part of the skin, with tenderness of the scar in the temporal region. All these symptoms disappeared, however, five days later, and the patient recovered thoroughly. The microscopical examination of the fluid showed that it contained white blood-cells in a state of degeneration, and a few mucous threads and flat epithelial cells. The result of the chemical examination of the fluid was—sp. gr. 1006, feeble alkaline reaction; with nitric acid, distinct reaction of albumen; besides these was found Na Cl (0.73 per cent.), and sugar (between 0.05 and 0.1 per cent.).

HOLGER MYGIND.

**FINNE, G.** (Norway).—**Nervous Symptoms arising from Diseases of the Nose.** *Norsk Magazin for Lægevidenskaben*, June, 1887.

THE author quotes the following cases:—1. An anæmic woman, aged fifty, had been treated for neuralgia of the first and second branches of the fifth nerve with internal remedies for three months without any result. After repeated cauterization with chromic acid, applied to the anterior part of the left lower turbinated bone, the mucous membrane of which was swollen, while the other part of the nose was in a state of atrophic catarrh, the pains disappeared entirely. 2. Spasmodic asthmatic attacks in a young man without any pulmonary disease cured by the treatment of an atrophic catarrh of the nose with insufflation of nitrate of silver. 3. Lessening of asthmatic attacks of twelve years' standing in a man, aged fifty one, without emphysema, after removal of polypi of the nose.

HOLGER MYGIND

**HERZOG** (Graz).—On Purulent Secretions of the Nose. *Mittheilungen des Vereins der Aerzte in Steiermark*, 1887.

For the specialist there is not very much that is new in this lecture but it must be recommended to the medical practitioner as a very good essay on all those conditions which give rise to nasal secretions. The author's classification into diffuse and localized nasal secretions, seems very practical.

MICHAEL.

**SCHNELTHESS**.—Case of Rhinoscleroma. *Ziemssen's Archiv*, Bd. 41, pp. 1, 2.

THE patient had three tumours on the face : one on the nose, and two in the situation of the sacci lacrymales. The first tumour was as large as a walnut, covered the right half of the nose, and was of cartilaginous consistence. The other parts of the nose were also hard. The other tumours were of the same nature and consistence as the first. The hard palate was red coloured, thickened, and bleeding if touched. The uvula was destroyed, and in its place was a hole. There was also an adhesion of the pharyngeal walls with the palate. The laryngoscope revealed a stricture of the trachea. The patient was tracheotomized two years ago, and now wears a canula. The beginning of the affection dated from the year 1868 with the ocular tumours. The nose had been bad since 1879. No syphilitic symptoms could be found, and an anti-syphilitic treatment was undertaken without any effect.

MICHAEL.

**SCHÄFFER**.—Tuberculosis or Lupus of the Nasal Mucous Membrane of Dr. Max Bresgen. *Deutsche Med. Wochenschr.*, No 32, 1887.

THE readers of this Journal will remember that Dr. Schäffer has described cases of tubercular tumours of the nose which were microscopically examined by Prof. Nasse. We have also reported a remark of Dr. Bresgen, who believed that it was not tuberculosis but lupus. Dr. Schäffer replies that the cases were very minutely examined, and that Dr. Bresgen's case was only macroscopically examined, and believes that his first diagnosis was correct.

**BRESGEN** (Frankfurt o/Maine).—Tuberculosis or Lupus of the Nasal Mucous Membrane. A Reply to Dr. Schäffer's Answer. *Deutsche Med. Wochenschr.*, No. 37.

Dr. BRESGEN does not doubt that there was a tubercular process present, but since bacilli are found in lupoid tumours, and lupus granulations are not always seen *in vivo*, he believes it is not right to call this affection "tubercular tumour," and, moreover, Dr. Orth says



that tuberculosis of the nose does not exist in granular form. He also communicates the microscopical examination of his case, made by Weigert.

MICHAEL.

**CARTAZ.**—On Nasal Tuberculosis. *France Médicale*, July, 1887.

THOUGH the nasal mucosa cannot escape this condition, it is rare, if one puts on one side lupoid affections, as to which great diversity of opinion exists. Cartaz has only been able to find eighteen cases of this disease, of which one came under his own observation. Nasal tuberculosis occurs under two forms, one consisting of ulceration, the other neoplastic: Ulceration, which is usually unilateral, is situated on the septum, a little distant from the nasal meatus. The ulcer has a diameter of 1—2 centimetres, and a form more or less rounded. The base is pale reddish grey, and covered with muco-pus; caseous masses are seen embedded on certain anfractuositities of the ulcer, or fine grey granulations are seen in relief. The edges of the ulcer are sometimes projecting, sometimes forming, sometimes a light grey ring, sometimes sharply cut and toothed with small excavations. There is little pain, or interference with nasal respiration.

In the second form there is usually a tumour, and coincident coryza, interference with respiration, and the diagnosis will be uncertain unless pulmonary signs are present. Cartaz recommends galvano-caustic applications, lactic acid, and iodoform.

JOAL.

**CAIRD, F. M.** (Edinburgh).—Naso-Pharyngeal Tumour. (Exhibition of specimen before the Medico-Chirurgical Society of Edinburgh, June 15, 1887.) *Edin. Med. Journal*, October, 1887.

NOTHING of importance.

HUNTER MACKENZIE.

**JACOBSON, NATHAN** (Syracuse, N.Y.).—Removal of Naso-pharyngeal Tumour, after Preliminary Resection of the Superior Maxilla. *Trans. of the New York State Medical Association*, November 17, 1886.

FIBRO-MYXOMA in boy of seventeen. After a preliminary tracheotomy, the method of Fergusson was done, and the superior maxilla, excepting the orbital plate, was removed; and the operation completed with the Paquelin cautery. There had been no recurrence in nine months. After giving a detailed history of the case, and a review of the literature of the operation, he proceeds to summarize the conclusions derived from a study of all the cases operated on in the United States. To ascertain the views of the profession, letters were addressed to many of the leading surgeons and laryngologists of the country, and the author's paper contains the analysis of the result. To those



about to perform this capital operation, Dr. Jacobson's paper will be of very great value.

JOHN N. MACKENZIE.

**BRAUN** (Triest).—**Case of a Tumour of the Naso-pharynx.** *Internat. Klin Rundschau*, No. 27, 1887.

Two tumours of the middle conchæ of the nares were operated upon with galvano-caustic wire. Before the operation the patients had infiltration of both lungs, anæmia and vomiting. A short time afterwards all symptoms had disappeared. The author believes that they were reflex phenomena resulting from the naso-pharyngeal tumour.

MICHAEL.

**GILES, W. A.**—**Post-nasal Vegetations.** *Australasian Medical Gazette*, June, 1887.

THIS paper deals specially with the treatment of such growths, and is illustrated by two successful cases. The methods and instruments employed by some authorities are first detailed—Meyer, of Copenhagen, with his ring-knife introduced through the nostrils; Guye, of Amsterdam, who uses the index finger; Dalby, of London, who also makes use of the index finger, but shod with a steel nail. Löwenberg, of Paris, and Woakes, of London, both of whom employ specially devised forceps, those of the latter being merely a modification of those of the former. Mr. Giles, in operating, had both patients under chloroform, the shoulders propped with pillows, and the head hanging over the end of the table. Guided by the left index finger, he introduced Löwenberg's forceps (Woakes' modification), by which he removed the growths one by one until the cavity was almost clear, after which the small sessile tumours and ragged pieces of mucous membrane remaining, he removed with Meyer's ring-knife introduced through the nostrils. The hæmorrhage, profuse at first, escaped through the nostrils, and as soon as the operation was completed it stopped. No after-treatment was employed. In both cases a perfect recovery followed.

J. WALKER DOWNIE.

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## LARYNX.

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**MOIR, D. M.** (Edinburgh).—**Case of Cut Throat.** Specimen showed to the Medico-Chirurgical Society of Edinburgh, June 15, 1887. *Edin. Med. Journal*, October, 1887.

ALTHOUGH neither the larynx nor the pharynx was injured, yet the infiltration of blood and serum had penetrated beneath the lining membrane of the larynx and trachea, so as to occasion a fatal œdema

glottidis on the evening of the second day. Tracheotomy is consequently suggested as a prophylactic measure in such cases.

(It is incomprehensible why this patient was allowed to die of "œdema of glottidis" (sic). Why was not the windpipe opened?)

HUNTER MACKENZIE.

**COUÉTOUX** (Nantes).—**Accident During the Application of the Stomach Pump. Introduction of the Tube into the Air-Passages.**

*Annales des Mal. du Larynx, &c., July, 1887.*

THE author, in endeavouring to wash out a stomach, introduced Faucher's tube into the larynx, then thinking he had an obstruction of the tube by aliment, he tried to remove it by giving a strong blast. The patient instantly became violet and sank upon the chair. In a short time respiration was re-established, cyanosis disappeared, and the patient could speak. Ten minutes afterwards he was quite recovered.

JOAL.

**LA COUNT, D.** (Chilton, Wisconsin).—**Foreign Bodies in the Air-Passages.** *Journ. of the Am. Med. Assoc., Sept. 17, 1886.*

FOREIGN bodies in the air-passages may produce death, either within a few hours or after prolonged suffering, with destruction of one or both lungs, accompanied by symptoms closely allied to tuberculosis of the lungs, without any suspicion on the part of the attendant as to the true cause of the disease while the patient lives. La Count believes that foreign bodies in the left bronchus do not cause death so soon as when they lodge in the right, for the reason that, the right lung being somewhat larger than the left, there is more breathing surface left, although it would seem that this difference in size would not be sufficient to prolong a patient's life for six months. Statistics show that the death rate is 16·87 per cent. greater in cases operated on than in those in which no operation had been performed. Four cases illustrative of the above propositions are detailed at length by the author.

J. N. MACKENZIE.

**COHEN, J. SOLIS** (Philadelphia).—**Electric Cauterization and Evulsion of Morbid Growths on the Vocal Bands.** *Med. News, September 3, 1887.*

(1) WHEN a growth on the edge or lower surface of a vocal band is to be attacked by the cautery the platinum blade should be covered upon one side with asbestos, upon which a thin plate of ivory is laid, the whole being firmly secured by the insulating material of the conducting wires. By this means injury to the sound side in the spasm likely to attend cauterization is avoided. The same applies in the nose, &c. The conducting copper wires should be very thick.

This confines the greater resistance to the current in the platinum terminal, and the body of the instrument does not become heated as it does when thin wires are used. (2) For minute neoplasms on the upper surface of the vocal band which cannot be grasped with the ordinary olive-shaped blade, Cohen employs a forceps in which the terminal of the blade is squared, and has with it removed growths no larger than hemp seeds from the anterior portion of the vocal band. The instrument is also serviceable in the removal of cysts, and in ripping off thickened tissue from the vocal bands of vocalists. Two cuts are given of the electrode and forceps.

J. N. MACKENZIE.

**BRESGEN** (Frank. o/M.).—**Laryngoscopy** (*Eulenburg's Real-encyclopædia*, 2nd Edition.

GOOD encyclopædic review.

**BRESGEN** (Frank. o/M.).—**Larynx.** *Ibid.*

GOOD encyclopædic review of the anatomy of the larynx.

MICHAEL.

**LUBLINSKI** (Berlin).—**On a Case of Tracheal Stenosis, successfully treated by Catheterism of the Trachea.** *Berl. Klin. Wochenschr.*, No. 37, 1887.

THE patient, nineteen years of age, was tracheotomized because of diphtheria in his second year. From this he always had great dyspnœa, which was ever increasing. The laryngoscope revealed a stenosis of the trachea, the lumen of which was only four centimetres. The patient was cured in a short time by catheterism with elastic bougies. Cases of tracheal stenosis, which are not syphilitic, are very rare.

MICHAEL.

**CHABANAT.**—**Tubage of the Glottis.** *Thèse de Paris*, 1887.

TUBAGE of the larynx is no more difficult to perform than tracheotomy. The canula may be kept in place many days and even weeks without any serious inconvenience. Facts published up to the present sufficiently demonstrate the use of the method in croup, so long as the patients are under the supervision of a competent person, so long as the attempts made at intubation be not multiple, and provided the operation be not performed *in extremis*. In ordinary practice, where the patient cannot be under the supervision of a competent person, intubation of the larynx gives no security to the patient, or to the surgeon.

JOAL.

**CAILLE** (New York).—**On Intubation of the Larynx.** *Berlin Klin. Wochenschr.*, No. 32, 1887.

A GENERAL review, recommending this method.

MICHAEL.

**HUBER, F.**—Intubation: A Study of Forty-seven Cases.

**O'DWYER, J.**—Feeding after Intubation of the Larynx.

**BROWN, DILLON.**—Statistical Records of Intubation.

**NORTHRUP, W. P.**—Pathological Anatomy of the Respiratory Tract after Death from Laryngeal Diphtheria and Intubation.

**HANCE, IRWIN H.**—Case of Laryngotomy after Intubation.

*Medical News*, June 11, 1887. (Report of New York Academy of Medicine, June 2, 1887.)

**HUBER.**—Tracheotomy should be performed only when intubation has failed to relieve. Intubation has passed through its experimental stage. Of forty-seven cases, twenty-nine, with eleven recoveries, were in children under three years of age; eighteen, with nine recoveries, in children of three years or over. Of the eleven children under three, one was nine-and-a-half months old; one, ten-and-a-half; two, eleven months; one, one year; two, two years; two, two-and-a-half years; and two, two years and eight months old. Of all children he had been called to treat for laryngeal stenosis, he had found it necessary to resort to intubation in only one out of every three or four; the operation should not be done till dangerous symptoms supervene. He used it, in fact, in exactly the same cases in which he would have performed tracheotomy a year ago. After going into the differential diagnosis, in which he drew attention to the possible confusion of the dyspnoea caused by empyema and retro-pharyngeal abscess with that produced by laryngeal stenosis, he proceeded to discuss the various accidents during the operation. O'DWYER's gag is apt to be displaced by the struggles of the child, which is not the case with Denhart's. The thread attached to the tube should be 18 to 20 inches long, and, if not withdrawn at once, should be passed over the ear and secured. In order to avoid accidents, the efforts to place it in position should be short and repeated rather than kept up continuously and uninterruptedly for any length of time. In a case in which the dislodged membrane was pushed before the tube he gave brandy, which excited cough with expulsion of both tube and membranes. Noisy breathing is an indication for removal of the tube. The latter has been coughed up and swallowed. After discussing the various accidents which had been reported in the past, he went on to say that in favourable cases the tube may be removed as early as the fourth or fifth day, although it is often desirable to leave it in longer. It may be dispensed with at a much earlier date than the tracheotomy tube. It is advisable to leave the tube in until all traces of diphtheritic patches in the pharynx have disappeared. No age contra-indicates intubation. No positive prognosis should ever be



made, however, until forty-eight hours have passed from the time the tube was introduced. Internally, Huber relies greatly on mercury, given after the method of Jacobi.

O'DWYER exhibited tubes to overcome the difficulty in feeding; also specimens with the tube in position. After describing no less than five modifications of his original instrument, he said that the last modification which he had adopted was to give to the upper portion of the tube a double backward curve, with the hope of increasing the facility of swallowing, and this, at all events, had the effect of preventing ulceration of the anterior wall of the trachea, which hitherto had been sometimes quite extensive. Any one who practises intubation extensively must be provided with a variety of tubes to suit individual cases. Notwithstanding all his modifications, he said he still found about the same difficulties of swallowing present. Solids and semi-solids are, as a rule, taken better than fluids. Food will not enter the tube if the epiglottis be normal. In a number of instances he had removed the tube in order to give nourishment, but the results were no better than when it was in position. In some cases, particularly when nephritis was present, there were nausea and vomiting, as well as anorexia. Sometimes swallowing is more readily accomplished than before the insertion of the tube, on account of the relief it furnishes to the urgent dyspnoea. When the patient was old enough to understand, he gave directions that swallowing should be done rapidly, and that as large a quantity of fluid as possible should be taken at one time. Then, by coughing, the tube could be freed. Sometimes he employed rectal alimentation, but seldom used the stomach pump. Speaking of pneumonia, O'Dwyer said that it might arise—(1) from secretions in the lower air-passages; (2) excess of blood drawn out of the lungs; (3) atelectasis in severe cases in which there was an extension of the membrane; (4) the presence of a tube either in the larynx or trachea. He did not believe in pneumonia from food in the minute bronchi, as food had never been found in that situation. One patient wore a tube in the larynx for over ten months, and not only did not take pneumonia, but in the meanwhile recovered from a bronchitis which she had had at the time the tube was introduced. He had lately devised two hard rubber tubes for all kinds of acute stenosis of the larynx in adults, which he described.

BROWN.—There have been so far reported 760 cases by fifty-four different operators, and of these he had tabulated 502 cases; 211, or 27·07 per cent., had recovered. The average age of the children who died was three years and two months; of those who recovered, four years



and one month. In those who recovered intubation had been resorted to at an average period of two days and nine hours after symptoms of laryngeal stenosis had first appeared, and in those who died, at an average period of one day and nineteen hours. In the fatal cases the average time after intubation at which death occurred was two days and eight hours, and in those which recovered, the average time during which the tube was worn was five days and three and a half hours. In 339 fatal cases, the causes of death were given. Unavoidable accidents are rare, and, with the exception of pushing the membrane before the tube, were not important. False passages had been made in two instances from the use of too much force. In order to avoid pushing the membrane, the tube should be pressed well down and held firmly in position with the finger until the obstruction has been removed. Coughing up the tube is dangerous, but may be avoided by using a tube with a sufficient retaining swell. This accident is, however, liable to occur if there be paralysis of the muscles, notwithstanding the swell. Extension of the membrane to the bronchi is the most frequent cause of death after intubation; pneumonia, when present, is secondary in character.

NORTHROP had reported eighty-seven fatal cases in December last. Since then twenty additional fatal cases had occurred at the Foundling Asylum, from the occurrence of diphtheria in connection with a fatal epidemic of measles and scarlet fever. All the fatal cases had pneumonia, and thirteen of them nephritis. In the twenty later cases, there were deep ulcers, laying bare the rings of the trachea in no less than five instances. (The specimens were shown.) He had not as yet met with ulceration of any consequence caused by the head of the tube—nothing more, in fact, than necrosis of epithelium. He had never seen any indication of “aspiration-pneumonia,” as it was called, due to the entrance of milk or other fluid into the finer bronchi.

HANCE.—Child, twenty months old. Scarlet fever and diphtheria; tube, introduced five times, failed to relieve, and the stenosis continuing, laryngotomy through the crico-thyroid membrane was done, with complete relief. The child died the next day, from the scarlatinous trouble. Nine similar cases, including his own, had been reported, with three deaths and five recoveries, while in one instance the child was still under treatment. The operation had been performed or advised in—(1) irritability of the larynx; (2) when membranes were pushed before the tube; (3) in plugging of the tube from membranes; (4) in return of dyspnoea with absence of the tube from the larynx; (5) when the tube becomes wedged in the

larynx. The laryngeal spasm can usually be controlled with belladonna, nitre, and chloral. He advised resort to tracheotomy only after intubation fails.

In the discussion of the above papers, Dr. O'DWYER said he had only once resorted to tracheotomy after intubation. His experience was unfavourable with tracheotomy. In removing false membrane, as the subglottic division of the tube is of such narrow calibre, he had devised a flexible apparatus somewhat on the principle of the umbrella probang. Wedging was not likely to occur. He had seen no aspiration-pneumonia.

The President (Dr. JACOBI), inquired if lobar pneumonia is of frequent occurrence, and if so, whether it is found chiefly in cases of sepsis.

Dr. NORTHRUP replied that in the eighty-seven cases previously reported by him, twenty-seven were believed to have died from extension of diphtheritic membrane; in a large proportion, the membrane extended from the tip of the nose to the finest bronchi. Bronchial diphtheria with œdema was a marked feature at the autopsy. Pneumonia, when it did occur, was of late origin. It affected both lungs and was lobular, not lobar, in character. In not more than one-fourth of the cases could it be said to have caused death.

Dr. CAILLE thought it too early to speak a final word on the merits of intubation. Many of the cases were reported in such a way as to render them of no practical value. He had performed tracheotomy in twenty-one cases, with five recoveries; intubation in sixteen cases, with six recoveries. In his cases of intubation, diphtheritic membranes were observed in the nares and pharynx in nine instances. Most were seen in consultation, and intubation, therefore, done rather late. He believed all would have died without surgical interference, and one would have recovered had intubation been done earlier. In the majority of his fatal cases, death was due to catarrhal pneumonia. Intubation is preferable to tracheotomy in the majority of cases, especially when the pharynx and nares are affected. Tracheotomy is preferable in some cases—apparently hopeless with operation—provided the surgeon can operate and carry out the after-treatment under the most favourable conditions. The same statements apply to intubation with the present style of tubes.

JOHN N. MACKENZIE.

**LUBLINSKI** (Berlin).—**Laryngeal Phthisis.** *Deutsch. Medicinal Zeit.*, Nos. 53-55, 1887.

CLINICAL lecture, giving a good review of the latest ideas of the pathology and therapy of this disease.

MICHAEL.

**TISSIER.**—**Laryngeal Complications in Typhoid Fever.** *Annales des Mal. du Larynx, August, 1887.*

THE term laryngo-typhus has been applied to an ulcerative laryngitis accompanied with necrosis of the cartilages. The earlier French physicians fully recognized the condition. The author describes several varieties of laryngeal complications in typhoid fever. During the first stage of the disease there is sometimes an *erythematous laryngitis*, with similar condition of the pharynx, tumefied tonsils and pultaceous deposits on them. This condition is without gravity, and requires no special treatment.

*Follicular laryngitis* is a manifestation of the second period of the disease. It ends often in ulcerations. *Ulcerative laryngitis* is of prognostic gravity. It is often the first stage of the severe laryngo-typhus. It occurs during the third week; chondritis supervenes later, when the patient is supposed to be convalescent. Aphonia and painful deglutition are frequently present. Œdema glottidis or purulent infiltration of the laryngeal mucosa may occur, causing death by asphyxia. It is particularly liable to occur at the end of a prolonged typhoid attack, especially adynamic or during convalescence, and is caused probably by a chill. Sudden laryngeal symptoms arise—aphonia, dyspnœa, stridor, cyanosis, and asphyxia—and the introduction of the finger reveals the cause, viz., epiglottic or aryepiglottic tumefaction. Death commonly results.

*Ultero-necrotic laryngitis* is rare in children, but generally attacks adults much debilitated by a long or severe illness. It occurs during the second or third week, or during convalescence. It remains obscure, or suddenly develops œdema glottidis. Voice is altered and may be aphonic; respiration is dyspnœic; suffocation may occur. Deglutition is painful; likewise pressure over the larynx. Prognosis is very grave. It is difficult to recognize if there is concurrent necrosis or perichondritis, since laryngoscopic examinations are impossible, but localized pain on pressure or swallowing, rejection of pus, &c., aid the diagnosis. Subcutaneous emphysema of the neck occurs sometimes.

*Laryngitis pseudo-membranosa* is often not recognized till after death, in consequence of the patient's inability, through enfeeblement, to call attention to the larynx. Death is the ordinary termination. It occurs towards the end of the second week, does not spread to the throat, and the dyspnœa being thought due to the concurrent adynamia and pulmonary condition. False membranes may even reach up to the finest bronchi.

*Gangrenous laryngitis* is quite exceptional.

The author then discusses the laryngeal affections of the nervo-muscular order in typhoid, and the relation of crico-arytenoid arthritis to these affections, the pathology of these affections, and concludes an able paper with remarks as to treatment. Catarrhal, follicular, and simple ulcerative laryngitis call for no especial treatment; tracheotomy is, however, urgently called for in the phlegmonous forms. Whenever in doubt this operation should be performed, and the results are encouraging. JOAL.

**WEGENER.**—**Paralysis of the Laryngeal Muscles as a Symptom of Tabes Dorsalis.** *Inaugural Dissertation. Berlin, 1887.*

REPORT of eight cases previously reported, with two new cases. All had nearly the same laryngoscopic appearance, viz., permanent immobility of the vocal cords in median position. The author urges the necessity of laryngoscopic examination in cases of central diseases as an important aid to diagnosis. In his cases he had good effect from the use of pot. bromide, and therefore believes that the "crises laryngées" are spastic attacks, the primary factor in which is paralysis of the abductors. MICHAEL.

**LUBET.**—**Study of Paralyzes of the Laryngeal Muscles.** *Thèse, Paris, 1887.*

A SUCCESSFUL review of the symptoms, etiology and therapeutic indications of this class of disorders. A very conscientious study. JOAL.

**POYET.**—**Membranous Occlusion of the Larynx.** *Bulletin Méd., September 18, 1887,*

A CASE in which the vocal cords were joined at their free borders by a deep red membrane occupying nearly all the glottic opening. The author publishes this case because membranous occlusions of the larynx are rare, and all observations recorded refer them to syphilis. This case, however, proves that an ulcerative affection accompanied with œdema of the vocal cords may lead to malformations in the larynx. JOAL.

**BROWNE, LENNOX.**—**On an Unrecognized Cause of Some Throat Ailments.** *New York Medical Journal, October 8, 1887. Philadelphia Medical News, October 8, 1887.*

THIS paper was the subject of an address delivered by request at a special meeting of the Philadelphia County Medical Society, of which Dr. Solis-Cohen is the president. The author refers to a former paper read at Milan in 1880, in which he endeavoured to show that almost all subjective symptoms, even those which are considered of



an hysterical or phantom character, may be traced to some objective condition in the throat. The chief of these are :—1. A varicose and even truly hæmorrhoidal condition of the veins at the base of the dorsum of the tongue, and superior surface of the epiglottis. 2. An enlargement of the circumvallate papillæ at the back of the tongue. 3. An engorgement and fulness, not always amounting to enlargement, of the thyroid gland.

These local conditions are associated with constitutional evidence of an enfeebled vaso-motor, and often with concomitant sign of a varicose diathesis. There are rectal hæmorrhoids, varicocele, or varicose veins of the extremities. Treatment consists principally in the destruction of these veins by the galvano-cautery point, and the administration of suitable tonics. In some cases there are associated other morbid conditions of the throat ; but these are not cured unless the varix is recognized and treated also.

## NECK, &c.

**LIÈGEOIS.**—*The Various Symptoms of Exophthalmic Goître. Rev. de l'Est., June, 1887.*

THE author publishes the details of a case in which tremor was marked, and which led him to diagnose Graves's disease, although there was neither goître nor exophthalmos. In this patient there were also paresis of the limbs, gastric troubles, bouliminia, anorexia, and vomiting. Urticaria, pseudolipomata, and simple polyuria were also present. The author relied on treatment by tincture of veratrum viride in 10-30 drop doses.

JOAL.

**SAINTE - MARIE.**—*Contribution to the Study of Graves's Disease. Thèse, Paris, 1887.*

BESIDES the well-known triad of symptoms, this disorder is manifested by a crowd of symptoms of a nervous order, and the recognition of which is of the first importance for the diagnosis of obscure cases. The principal of these are, tremors, transitory pareses, localized hyperæsthesiæ, secretory troubles of the skin and kidneys, sometimes obstinate vomitings, oftener still paroxysmal diarrhœa, vaso-motor disorders, with increase of temperature, the sensation of "dead fingers," buliminia, nervous cough, cutaneous trophoneuroses, and lastly, modification of electrical resistances. To these phenomena, of which the greater proportion have only recently been recognized, must be added scleroderma, and supra-clavicular pseudo-lipoma.

JOAL.



**FRASER, T. R.** (Edinburgh).—**Case of Exophthalmic Goître.** *Edin. Med. Journal*, Oct., 1887. (Exhibition of case before the Medico-Chirurgical Society of Edinburgh, June 15, 1887.)

IN this case the greater portion of the thyroid gland had been removed by Professor Lister ten years previously. The operation had relieved all the symptoms of exophthalmic goitre, but had been followed by general convulsions without loss of consciousness, which occurred at each catamenial period; these have now disappeared. No evidence of myxœdema was present. A portion of the gland (isthmus) still remained.

HUNTER MACKENZIE.

**DUNCAN, J.** (Edinburgh).—**Two Cases of Tumours of the Neck.** *Edin. Med. Journ.*, October, 1887. (Exhibition of cases before the Medico-Chirurgical Society of Edinburgh, June 15, 1887.)

BOTH cases were operated on with satisfactory results. The first case was a sarcoma reaching from the omo-hyoid to the angle of the jaw. Three inches of the internal jugular and a portion of the hypoglossal nerve were removed. The tongue was drawn to one side, but subsequently recovered. The pneumo-gastric and superior laryngeal nerves were exposed and freely handled. He immediately developed a raucous voice and a short cough, with some retching. The second case, after operation, showed no nerve effects, although the gustatory, hypoglossal, and pneumo-gastric nerves had been freely exposed.

HUNTER MACKENZIE.

**LELOIR.**—**Researches on the Nature and Pathological Anatomy of Buccal Leucoplasia.** *Acad. des Sci.*, June, 1887.

THE Lille professor has, since 1882, observed thirty-five cases in which the mucous membrane was affected with lingual psoriasis, and has been able to confirm completely his former researches. He regards buccal leucoplasia as "hyperkeratinisal" at first, tending to erosions under the influence of various causes, amongst which are irritation secondary to the production of fissures and ulcerations. This irritation leads also to production of papillomatous excrescences, which degenerate into epitheliomata. One may say that epithelioma is only the indirect consequence of leucoplasia. In the commencement of this complaint salicylic acid, in particular, is indicated for local treatment.

JOAL.

**DESCROIZELLES.**—**Ultero-Membranous Stomatitis.** *Gaz. des Hôpitaux*, July 7, 1887.

THE author recommends the use of chlorate of potash in this affection.

JOAL

**COUTENOT.**—**Angiomas of the Tongue.** *Thèse, Paris, 1887.*

WHENEVER a lingual angioma gives rise to any symptoms it is necessary to thoroughly ablate it. Spreading angioma is an affection too grave to be neglected. Its gravity is deduced from its seat, its progress, and its arterio-venous or cavernous nature. In case of stationary angiomas it is necessary to abstain from all treatment, unless urgent symptoms are present and call for it. For treatment the author suggests:—1. The injection of coagulants. 2. Electrolysis (in case of tumours situated deeply). 3. Central cauterizations by the thermo-cautery. 4. Simple or multiple ligature. 5. In special cases extirpation, with or without the aid of the ligature and cautery. All operations leading to loss of blood should be avoided in young children. JOAL.

**DIDAY.**—**Recurrent Herpes of the Tongue.** *Soc. Méd. de Lyon, July, 1887.*

THE author formerly professed the opinion of Fournier, that certain ulcerations or erosions of the edges of the tongue in subjects with a syphilitic history were not of a specific, but of a herpetic nature, and were thus no contra-indication to marriage. Now he holds the opinion that these lesions may communicate a buccal chancre. Since they do not possess characteristic herpetic signs, one should hesitate to include them in this category. JOAL.

**CHIEN I. E.** (Edinburgh).—**Demonstration of the following Specimens before the Medico-Chirurgical Society of Edinburgh, June 15, 1887.** *Edin. Med. Journ., October, 1887.*

(1) Two tumours of the lower jaw, one of which was cystic.

(2) Epithelioma of the tongue removed from a man, who was also the subject of syphilis, after a preliminary tracheotomy.

(3) A larynx containing a foreign body. The practitioner was sent for to see a child, aged six months, who was said to be suffering from croup, and found it dead. On making an examination he found a piece of eggshell in the larynx. HUNTER MACKENZIE.

**GLEITSMAN, J. W.** (New York).—**Zweiter Jahresbericht der Halsabtheilung des Deutschen Dispensary in New York.** *New Yorker Medizinische Presse, April, 1887.*

ANALYSIS of 1770 cases, for granular pharyngitis. The best results were obtained by the cautery and chromic acid. Once serious secondary hæmorrhage followed the extirpation of the tonsil, but was checked by compression with the finger. Follicular inflammation of the tonsils occurred with great frequency, and was successfully

treated by the operation of multiple scarification. Of the cases of laryngeal phthisis, treated in 1885 by lactic acid, few remained long enough under treatment to justify praise or condemnation of the method. While lactic acid undoubtedly is a valuable local application, it does not prevent the formation of ulceration, and fresh infiltration in other parts of the larynx. Dispensary patients seem to complain less frequently of reflex nasal symptoms than those in private practice. Gleitsman reports several cases—among them, one in which acne rosacea disappeared after the removal of nasal obstruction, one of cyst of the pharyngeal bursa, and one of tumour of the nasal pharynx (no microscopical examination).

JOHN N. MACKENZIE.

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## ASSOCIATION AND CONGRESS MEETINGS.

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### Ninth International Medical Congress.

*Washington, September, 1887.*

#### PAPERS READ IN THE SECTION OF LARYNGOLOGY.

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#### I.—*Three Supra-Epiglottic Benign Neoplasms.* (a) *Cyst of the Posterior Pharyngeal Wall*, by Dr. WILLIAM PORTER.

THIS was the case of a poor woman, about twenty-seven years of age, whom I saw in my clinic. Her only symptom was dysphagia, and the constant evidence of something "sticking in her throat." A direct examination revealed a cyst of the mucous membrane about one-half inch in diameter, and projecting fully three-eighths of an inch from the posterior pharyngeal wall, a little below the level of the tonsils. With a curved pointed bistoury the sac was freely laid open by cutting from below upwards. To the inner surface tinct. ferri hydrochlor. was applied, and the patient made a quick recovery, though until she ceased her visits there was some thickening at the site of the cyst.

A mucous cyst projecting from the back of the epiglottis, and partly covering the glottis, is recorded by Durham (*Med.-Chir. Trans.* xlvii.), also retro-tracheal gland cysts are described by Gruber, which opened by several sinuses into the trachea.

(b). The second case is one which is yet under observation (August 10, 1887). A young married lady, very nervous but of good physique, was brought to me on account of an incessant cough and

some difficulty of swallowing. A papillary growth was found, having its origin just below the left tonsil, but entirely distinct from it. The papilloma encroached upon and hung over the left wing of the epiglottis. It was as large as an ordinary Malaga grape, having a thick strong pedicle. The patient declined operative interference, but I succeeded in getting her to consent to the application of a destructive agent. Chromic acid was repeatedly applied to the pedicle, and in a fortnight the nutrition of the tumour was evidently much impeded, and in another week it sloughed so nearly off that it was easily detached by forceps. The troublesome cough is almost gone, though the patient has yet some irritation about the original site of the tumour, but this is disappearing.

Luschka (*Virchow's Archiv.* vol. i) and Sommerbrodt (*Ibid.*, vol. li.) have each described cases of pharyngeal papilloma, while Mackenzie (*Diseases of the Throat and Nose*, vol. i.) refers to several cases varying in size from a pea to a small grape. This author also refers to two preparations of pedunculated tumours removed during life, now in the Museum of the Royal College of Surgeons.

(c). *Chondroma of Epiglottis.*

I will merely refer to this case, as I recorded a full account of it, with the bibliography to date, in the *American Journal of the Medical Sciences*, April, 1879. The patient was a stock raiser, aged forty-four. A tumour was found occupying the left margin of the epiglottis, extending about three lines into the substance of the normal tissue, which caused difficulty in swallowing and some pain. It was easily removed by rectangular cutting forceps, and the margin rapidly healed. The growth was a chondroma directly connected with the epiglottic cartilage.

II.—*A New Procedure in the Treatment of Cystic Goitre*, by Dr. WM. PORTER.

DURING the past year several cases of cystic goitre have been treated, by what I believe to be a less objectionable method than the usual one of injecting the sac (after evacuation) by a solution of iodine or iron. I will give but one history, though the result has been good in all. A gentleman, having a large cyst of the thyroid gland, consulted me early last spring. The growth greatly interfered with his comfort, the trachea being pushed to the left in a marked degree. He objected to the usual plan of injection, as I told him it would probably necessitate his being confined to his room for some days. The fluid was drawn off by means of a small trocar and canula, and six inches of catgut steeped in tinct. iodine introduced



through the canula, which was then withdrawn, leaving a little of the foreign body projecting. As soon as there were symptoms of local inflammation evident the catgut was withdrawn. There was no annoyance from the treatment, and no return of the cyst.

(AUTHOR'S ABSTRACT).

III.—*The Action of the Epiglottis in Swallowing*, by Mr. CARMALT JONES.

It used to be taught that the epiglottis had an action like a lid, and that one of its functions was in the act of swallowing, to shut down over the larynx as if it were hinged on at the base of the tongue, and thus to prevent food, &c., from passing into the larynx, and that in addition, the epiglottis being thus tilted downwards and backwards, acted as a sort of guide or shoot for the food and directed it towards the upper end of the œsophagus when pushed backwards by the base of the tongue. (See Quain's *Anatomy*, 1876, p. 283, and Kirkes' *Handbook of Physiology*, edited by Marrant Baker, 1872, p. 264). I do not believe that the epiglottis has any such action. Occasionally it is seen with the laryngoscope hanging backwards, and so far covering the larynx that no view of the interior can be obtained, giving the idea that it would only have to shut down a little more to form a complete protection for the larynx against the entrance of foreign bodies, such as food, but also suggesting that in vomiting it would be in just the very position to intercept material on its passage upwards and forwards, and to direct it into the larynx. With the mirror I have often seen that the epiglottis has the power to close its sides together. The lateral borders approximate in the middle line, the front of the epiglottis remaining erect, and there is only a small round or oval opening behind the centre of the tip of the epiglottis. There are also cases where the epiglottis stands up very prominently behind the base of the tongue, and can be seen without the mirror; by drawing the tongue forward it can then be seen to diminish its breadth by folding its sides together, but is not seen to flap backwards.

One simple experiment can be tried by any one. Take a little water in the mouth, protrude the tongue as far as possible, close the teeth on it, and then, with the tongue thus held, swallow the water. It will be found that the water is perfectly easily swallowed without much movement of the tongue, but that a great deal is done by the muscles of the pharynx. Taking together the result of this experiment Kirkes' statement that even when the epiglottis is destroyed there is little danger of food passing into the larynx so long as its muscles can act freely, and the knowledge that in many cases where the epiglottis



can be seen by the laryngoscope to be largely eroded, yet the patient can swallow solids and fluids without any signs of choking, I submit that in swallowing the epiglottis is not carried downwards and backwards over the entrance to the larynx, but remains upright and closes its sides together. (AUTHOR'S ABSTRACT.)

A general discussion followed as to the difference in action under irritation and simple swallowing. Dr. O'DWYER thought the epiglottis was often folded firmly about the larynx. Dr. C. S. ALLEN had seen a case in which the whole centre of the epiglottis had been destroyed, but the long thin borders were closely approximated and protected the larynx. Dr. PORTER thought the epiglottis only accessory, and the sphincters had most to do with closing the larynx.

#### IV.—*Recurrent Hæmorrhage of the Upper Air-Passages.*

Discussion opened by Dr. WILLIAM PORTER, of St. Louis, U.S.A.

MR. PRESIDENT.—Without attempting to present the subject fully, I will make some suggestions which may be profitably discussed. First let me limit the geographical boundaries of the term upper air-passages. Epistaxis forms the subject of another discussion, and we will not include it here. Bronchial hæmorrhage is rare, except as a complication of pulmonary disease, and is discovered by the use of the stethoscope rather than the laryngoscope. While many of us include diseases of the chest in our field of practice it is proper here that we should, as far as possible, confine our remarks to laryngological topics only. Excluding then, for these reasons, epistaxis and hæmorrhage from the bronchial tubes, let us turn our thought to recurrent hæmorrhage of the larynx and pharynx. Again I think we need consider those cases only in which the hæmorrhage is of idiopathic origin. Interesting essays have been written upon such themes as hæmorrhage following uvulotomy (Morgan) and tonsillotomy (Lefferts), but such phenomena these and other writers upon kindred subjects have mentioned can scarcely be called recurrent, but rather persistent and constant. Two cases may be used as illustrations of our subject.

The first was *recurrent hæmorrhage from the larynx*. Miss K., about eighteen years of age, with good family history, consulted me because of frequent bleeding, which she feared originated in the lungs. She had had some hoarseness and at times soreness in the glottic region, but not constantly. A careful examination of the chest did not enable me to locate the lesion. At that time I could not discover any abnormal condition suggesting hæmorrhage in the upper air-passages, although there was a chronic laryngitis and pharyngitis. A few days later bleeding came on, lasting for some

hours, and blood was expectorated at intervals. The source of the hæmorrhage was found to be a perforated ulcer (which had escaped my attention at the first examination) located on the right ventricular band, and after removing all the exuded blood by absorbent cotton the fresh blood could be observed coming from the ulcer. A solution of iron and glycerine promptly controlled the hæmorrhage. There was recurrence of the hæmorrhage several times, and the ulcer healed slowly. Rest was enjoined, phonation restricted, and after two weeks there was no return of the bleeding. There has been entire absence of the symptom for two months, and the laryngitis under treatment has improved, though not entirely relieved.

Where there is extravasation of blood into the submucous tissues of the larynx serious complications may ensue, and death may quickly occur from obstruction. One of the most interesting monographs upon this subject was published by Dr. Gleitsman, in the *American Journal of the Medical Sciences*, April, 1885. Hæmorrhage from the larynx is not a disease but a symptom, and must be treated as such. Generally resulting from some form of laryngitis—simple tubercular, or, in rare instances, syphilitic—yet a prominent factor in its production may be faulty cardiac action. In one case, at least, topical applications were insufficient, until the heart, unable to do its work through a mitral lesion, was aided by rest and digitalis.

*Hæmorrhage from the pharynx* may easily be mistaken for hæmoptysis. In 1882 I reported two cases to the American Medical Association in the Section on Laryngology. In each of these cases there was some slight pulmonary lesion, and when the hæmorrhage appeared it was but natural to think that its origin should have been in the lungs, and in each the true site was in the pharynx. Since then I have seen several similar instances, the following case being typical:—

Mr. N., a young attorney, of St. Louis, having had, during previous years, several attacks of bronchitis, was one day surprised by the rapid discharge of blood from the mouth. He was sure the hæmorrhage came from the right middle lobe, where he had had some pain during the attacks of bronchitis mentioned. The bleeding had ceased when I saw him, and though there was evidence of a slight chronic bronchitis, the percussion note, vesicular murmur, and rhythm were normal. Some days afterward Mr. N. again came. He had had slight bleeding several times during the day. In my search for the source, I passed a bent cotton covered probe into the upper pharynx, and was rewarded by the reappearance of hæmorrhage, the blood trickling down from behind the soft palate. A small ulcer

was found on the posterior wall of the velum a little to the right of the median line. There was no further hæmorrhage, the ulcer rapidly disappearing under slight treatment.

The thought which I would offer in submitting these condensed histories is that hæmorrhage from the upper air-passages is not infrequently a complication of chronic inflammation of the larynx or pharynx, and that it may be mistaken for hæmoptysis or even hæmatemesis. This being admitted in all cases of hæmorrhage from the respiratory tract of doubtful origin, there should be careful examination of the upper air-passages. (AUTHOR'S ABSTRACT.)

Dr. STOCKTON (Chicago) related the case of an actress who coughed up a large amount of bright frothy blood, apparently from the lungs. A small pulsating and spouting vessel was discovered on the right ventricular band, which was eventually destroyed by the galvano-cautery.

Mr. LENNOX BROWNE thought these hæmorrhages usually occurred in tubercular or syphilitic subjects, often from intemperance. Such patches are frequently found at the base of the tongue and above the epiglottis. Straining of the voice may cause congestion and dilatation of vessels.

V.—*Recent Views on the Pathology and Treatment of Tuberculosis of the Throat and Larynx*, by Mr. LENNOX BROWNE.

THIS paper was an elaboration of the views expounded in the discussion on laryngeal phthisis at the meeting of the British Medical Association at Dublin. For an abstract the reader is referred to the September number of this Journal, page 352.

In the discussion following, Dr. SINCLAIR COGHILL thought that the alleviation of pain and rest to the larynx were most essential. Insufflations of morphia and iodoform were the most successful, and he had seen cases apparently cured. The medium in which the bacilli thrive is more important than the bacilli themselves. Local treatment alone should not be relied on, but digestion and assimilation be improved.

Dr. SOLIS COHEN thought sulphurous treatment improved the tissues and prevented growth of the bacilli. He only knew of two cases of recovery from supposed tubercular laryngitis. He believed in scraping and lactic acid applications, and used also morphia, iodoform, and atropin. He condemned tracheotomy to obtain rest.

Dr. E. F. INGALS found it difficult to choose between high and low altitudes, but the former are injurious where the disease is advanced. Calcium and chlorides are beneficial. He had abandoned sulphurous

treatment, and had poor effects from lactic acid. Morphia, tannin, and carbolic acid was an excellent wash or spray.

Dr. COOMES believed in iodoform. He had seen a case recover even after the epiglottis had sloughed away.

Dr. CASSELBERRY thought lactic acid too irritating, and preferred iodol to iodoform.

Dr. STOCKTON had no success from scraping ulcers, and uses lactic acid from 10 to 90 per cent.

Dr. JOHN MACKENZIE was sceptical both as to cures and bacilli, and favoured constitutional treatment and bichloride of mercury (1-2000) locally.

Dr. CURTIS thought atropin of no use, but heals ulcers with sprays of nitrate of silver.

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### French Association for the Advancement of Science.

CONGRESS HELD AT TOULOUSE, SIXTEENTH SESSION, 1887.

*Clinical Considerations on Vocal Affections in Acute Catarrhal Laryngitis.* By E. J. MOURE (Bordeaux).

THESE affections are rather the result of affections of the muscles than of material lesions of the mucosa. The swelling, redness, and catarrhal condition produce simple, uniform hoarseness, but do not explain the brusque variations of the *timbre* of the voice in these affections. The muscles most often affected are the thyro- and crico-arytenoids. Paresis and paralysis of the transverse arytenoid especially explains the raucity of voice and cough and aphonia occurring in this affection.

*A Case of Laryngeal Polypus; Spontaneous Expulsion; Cure.* By CHARAZAC (Toulouse).

THIS was a papilloma, of the size of a small strawberry, occurring in a young woman of thirty-one, and giving rise to much dyspnoea and aphonia. The growth was expelled during a violent fit of coughing, and the larynx afterwards appeared normal, with the exception of the anterior third of the right vocal cord, where traces remained at the spot where the growth had been inserted, consisting of a filiform pedicle. Respiration became quite easy and the voice fairly clear. Six months afterwards every trace of the tumour had disappeared. Only two or three such cases are on record.

*The Treatment of Certain Hæmorrhages, by Revulsion over the Hepatic Region.* By L. H. PETIT.

A CERTAIN number of spontaneous hæmorrhages (epistaxis, hæmor-

rhoidal, &c.) and secondary traumatism owe their origin to the hepatic condition. Hepatic revulsion, by cold douches, or large blisters over the hepatic region, leads to the cessation of these hæmorrhages. The author communicates several new observations made by Pachard, Sales, and Gerard Marchant, since Verneuil's contribution on the subject to the Academy of Medicine (see p 231). Pachard reported the case of a lady with cirrhosis of the liver, in whom a rebellious epistaxis occurred, defying all usual methods for arrest. A blister over the liver stopped it.

Gerard Marchant reported a case of a man of sixty, who was attacked with epistaxis and bleeding from the gums after intermittent fever in 1874, and again in 1876 and 1878. In 1884 two teeth were removed and cauterization applied unsuccessfully, blood flowed freely from the nose and mouth for twelve days, and was finally arrested by sulphate of quinine. In May, 1887, abundant and repeated epistaxis occurred. Tampons would not arrest it. An enlarged liver was found, and Marchant applied a large blister over the hepatic region. The epistaxis was diminished in twenty minutes, and at the end of an hour was arrested, and has never recurred.

*The Action of Gaseous Injections.* By BERGEON (of Lyons).

WHEN carbonic acid gas charged with vapours of carbon disulphide and holding empyreumatic medicaments in solution, or traversing a large mass of natural sulphur water, is injected (per rectum) two or three times a day, the number of attacks of whooping-cough is diminished from the fifth day of treatment, and with fifteen or twenty injections one can obtain complete cure. Provided the dose be large enough the treatment is always successful for asthma and whooping-cough, and failures reported by detractors of the method are due to indifferent methods of applying it.

## REPORTS OF SOCIETIES.

### Berlin Medical Society.

*Meeting, July 13, 1887.*

Dr. STRASSMANN demonstrated some salivary calculi. The author made an incision into a ranula, and found a stone of two and a half centimetres in length. Another stone was found in the submaxillary gland, and the gland along with the calculus was extirpated. A third stone was found in the ductus Whartonianus of a woman fifty years old.

Dr. DAVIDSOHN also showed a calculus which he had found in the sublingual gland.

MICHAEL.



**Mittelfränkischer Aertzetag in Nürnberg.**

July 16, 1887.

ZENKERT (Erlangen).—*On Pachydermia Verrucosa Laryngis.*

THE patient, hoarse for some years, died of an intercurrent disease. At the autopsy, the larynx exhibited a good specimen of pachydermia. The vocal bands were enlarged, but not tuberos, so that macroscopically it might have been thought that there was pachydermia glabra, but the microscopic examination showed it to be of the verrucous form. Sections of the vocal bands revealed many papillary, and one warty growth. The author said that he agreed with Virchow, as to the benignity of the disease.

MICHAEL.

**Academy of Medicine.**

Paris, September 27, 1887.

*Imaginary Ulcerations of the Tongue.*—VERNEUIL called attention to this condition manifested by pain, often thought to be lingual neuralgia, but which produces the firm impression in patients that they are the victims of lingual cancer. The pain is fixed, localized, or radiating during mastication or deglutition, subject to exacerbations. The seat of the pain appears to be often the caliciform papilla. Possibly a psychical state renders the condition obstinate. Failing relief from ordinary medication, surgical intervention may be adopted.

1. Intra-lingual hypodermic injections. 2. Deep cauterization with the thermocautery. 3. The destruction of the caliciform papilla by the same means. Everybody has seen such cases, but no one has described them.

FOURNIER had often seen such cases, and ascribed them to gouty diathesis or tabes. Bronides internally or in spray often arrested the pain, and moral treatment was essential.

LABBÉ had often met with such cases. It is best to do nothing, medical or surgical, but to depend on moral treatment.

LABORDE thought that these cases were hypochondriacal and often prodromal of general paralysis. They are often seen in asylums.

*Meeting, October 4.*

HARDY, referring to VERNEUIL's observations, believed these pains due to hyperesthesia of the tongue in neuropathic individuals, or old syphilitics, who have taken much mercury, without ulceration of the mouth. Alkaline treatment and phenic preparations were the best.

LUYS thought that it was more particularly in hypochondriacal persons that these pains occurred, and they are often precursors of general paralysis or hypochondriasis.

DIDAY (Lyons) thought VERNEUIL had with perfect right differentiated these cases from simple neuralgia. Though in the latter there is also pain, in the cases signalized by VERNEUIL ulceration—though only alleged—figures. The affection is often referred to the posterior third of one edge of the tongue, and the vertical folds normally existing there when hypertrophied, after excessive use of tobacco and alcohol, can give rise to the impression that the interval separating the folds is really ulcerated.

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**REVIEWS.**

**SCHWARTZ, Dr.**—*On Growths in the Larynx.* Paris: Librairie Bailliere et fils, 1886.

IN this very important book, as attractive in its form as interesting in its intrinsic matter, the author treats *in extenso* of all growths of

the larynx. He excepts only tumours of tuberculous or syphilitic nature which belong rather to the special study of these affections. The reader must not expect to find in Dr. Schwartz's work many original observations. It is not the production of a specialist in laryngology, but of a learned surgeon who has made a very conscientious and profound study of a subject dear to himself, and now gives to the public the result of his researches. The beginner and the student will very soon become acquainted with the vast question he handles; the practised laryngologist will find therein the results of all work published within the last ten years.

The work is divided into two parts. The first comprehends the tumours intrinsic to the larynx, and which have no tendency whatever to destroy its framework or to encroach on the neighbouring parts. They are *benign* tumours. The others, on the contrary, spread gradually to the neighbouring tissues, destroy all the elements they invade and end by cachexia. These are *malignant* tumours.

The author begins the study of benign tumours with a detailed history of the question. It contains three distinct phases, the first extends from Lieutaud to Ehrmann (1754-1850): they were then considered as beyond the resources of art. The second extends from 1850 to 1858; thyrotomy was practised more than once after the example of Professor Ehrmann. Finally, the modern period extends to our day. The endo-laryngeal method, thanks to the discovery of the laryngoscope, obtains the most signal triumphs.

Pathological anatomy is treated with great care. Generally, tumours proceed from the soft parts, exceptionally from the structure itself of the larynx. After having studied successively the frequency and favourite seat, the author comes to the description of the different anatomical varieties, papillomata, fibromata, myxomata, adenomata, lipomata and cysts; and finally, rare forms, such as enchondromata, and tumours formed by the tissues of the thyroid body.

The etiology and pathology are then dealt with. Statistics on the age, sex, diathesis and predisposition are given, then follows the symptomatology, functional and objective symptoms, the most important of which are furnished by the laryngoscopic mirror.

Diagnosis is treated from every point of view. Is there a tumour at all? Where is it? What is its nature? Those are the different questions to be considered. As for differential diagnosis all its difficulties are signalized. The author insists with reason on the preponderant value of laryngoscopic and microscopical examination. This portion is completed by a study of prognosis. The second part of the book, which refers to malignant tumours or cancer of the larynx, is by far the most important, and occupies 208 pages.

Dr. Schwartz gives us first its history, which had two great periods : the one, prelaryngeal, which extends from the observations of Morgagni till 1858 ; and the modern one, which includes the remarkable inquiries of Fauvel, Isambert, Krishaber, Morell Mackenzie, and others. Then he proceeds to the study of anatomical pathology. First of all, the author states an absolute but controvertible law, viz., that malignant tumours of the larynx proceed always from the soft parts, be they intrinsic, generated in the larynx itself, or produced by extension from neighbouring organs. The affection is generally unilateral. Only two varieties are met with : sarcoma, which may assume the fasciculated or the globocellular form—this being the most serious, since it approaches most to true cancer—and the carcinoma properly so-called, be it epithelioma or encephaloid cancer, both diseases invading essentially by degrees, destroying all the tissues, and producing the most extensive ravages. Two questions come now under discussion. Does cancer give rise to glandular swellings? Yes, sometimes, answers the author ; generally, no, so long as the disorder remains intrinsic. If it spreads to the pharynx or the œsophagus, adenopathy immediately appears, and is always more marked on the affected side. Has cancer a tendency to be generalized in the body? Generally, no, except in some very rare instances.

Epithelioma is more common than encephaloid. Its most common form is the pavement-lobular epithelioma, generally it is intra-laryngeal. Encephaloid prefers the superior orifice of the larynx and the epiglottis. As to symptomatology, Dr. Schwartz analyses successively the disturbances of deglutition, respiration, phonation, pain, cough, salivation, &c., then comes to the description of the different varieties as presented by the laryngoscope.

The differential diagnosis between benign and malignant tumours, then between these and the tuberculosis and syphilis, is sufficiently insisted upon. He comes back to the importance of the microscopic examination of a fragment of extracted matter. It is to be regretted that diagnosis is so difficult in the beginning, for there would be every chance of cure by vigorous intervention.

Now we come to the most important chapter, namely, the treatment. It would carry us much too far to make a complete and detailed analysis. The author begins with the treatment of benign tumours ; this must, as a general rule, be endo-laryngeal. It is but in very rare cases indeed that recourse must be had to a most important surgical intervention—laryngofissure, thyrotomy, and intercricothyro-tracheotomy. Besides, as he himself remarks in his work, a complete study

of the technique of the operations in the larynx must not be looked for, since the works of Fauvel, Mackenzie, Störk, Oertel, and many others fill that gap. Not so, however, for the treatment of malignant tumours; laryngotomy, complete or partial extirpation of the larynx, must be considered.

All wishing to make a special study of these questions should not fail to read attentively the chapters devoted to them. They as well as we will find that a real gap is filled in French literature.

Dr. Schwartz's conclusion deserves to be quoted:—"Notwithstanding the apparent chances of success, cancer of the larynx being the one remaining the longest localized, notwithstanding the progress of the operative art, therapeutic results have not crowned the efforts made. Palliative treatment, viz., symptomatic tracheotomy, will always be the rule so long as we do not know perfectly the nature and origin of malignant tumours, and that diagnosis does not allow us to discover them at their earliest stage."

CAPART.

## NOTES.

**The International Medical Congress.**—This year's Congress may have presented many unfortunate shortcomings compared with previous meetings. Several papers of great interest, however, were read, and the section in Laryngology was by no means one of the least busy. The English branch of the specialty was prominently represented by Mr. Lennox Browne; and our English readers will be pleased to note that British laryngology was cordially welcomed in his person. Mr. Lennox Browne was hospitably entertained by the leading laryngologists of New York and Philadelphia.

As we desire to present authenticated reports of the papers read in the Laryngological Section of the International Medical Congress, we beg that authors of papers will be good enough to forward us abstracts of the same for publication as soon as possible.

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ON EXTIRPATION OF THE LARYNX.

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THE operation of extirpation of the larynx for malignant disease was first seriously proposed in 1854 by von Langenbeck, to one of his patients, who, however, declined. Kceberlé later on, in a clinical lecture, advocated the operation, without, however, putting it into practice. It was Patrick Heron Watson, of Edinburgh, who, in 1866, was the first to demonstrate the practicability of the operation, by performing it upon a patient with tertiary specific disease of the larynx, with, however, a fatal result, the patient succumbing of pneumonia three weeks after the operation. Czerny was meanwhile making experiments in the same direction upon dogs at Heidelberg, and he concluded from them the practicability of the operation upon the human subject, the fact of which Watson had demonstrated meanwhile, unknown to him. In 1883, Billroth performed the operation at Vienna, and though to him is attributed the credit of bringing the operation into the region of practical surgery, this credit must be given to Watson, an ornament of a school which has ever been in the forefront of medical and surgical progress. From time to time various tables have been published, of collected cases of total and partial extirpation. Foulis, an ardent supporter of the operation, contributed a valuable statistical table to the transactions of the International Medical Congress in 1881. The work of Morell Mackenzie contains a valuable table, the most complete published up to that time. Since then, Baratoux, Hahn, Zesas, Schwartz, Solis-Cohen have each published statistics of recorded cases. The accumulated evidence of various operations has not tended to confirm the favourable hopes that were expected of total extirpation of the larynx, and the table we here present will serve to show that it is but a desperate proceeding at the best.



## TOTAL EXTIRPATION OF THE LARYNX.—I. FOR MALIGNANT DISEASE.

Operator.	Sex.	Age.	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
1. Billroth ...	M.	36	31 Dec., 1873	Carcinoma, epithelioma	Whole larynx, part of epiglottis, two tracheal rings	Recurrence in four months; death seven months after operation
2. Heine ..	M.	50	28 April, 1874	Epithelial carcinoma	Whole larynx	Death six months after from recurrence
3. Maas ..	M.	57	1 June, 1874	Carcinoma, adeno-fibroma	Whole larynx	Death thirteen days after from pneumonia
4. Schmidt ..	M.	56	12 Aug., 1874	Epithelial carcinoma	Whole larynx	Death on fourth day, collapse
5. P. H. Watson ..	M.	60	1874	Epithelioma of left vocal cord.	Whole larynx	Death two weeks after from pneumonia
6. Schonborn ..	M.	72	22 Jan., 1875	Carcinoma	Whole larynx	Death on fourth day
7. Von Langenbeck	M.	57	21 July, 1875	Carcinoma of larynx, epiglottis, and tongue	Epiglottis and whole larynx, part of tongue, pharynx, and oesophagus	Death, collapse. Recurrence four months after operation
8. Mullanowski ..	M.	59	27 July, 1875	Carcinoma	Whole larynx	Death three months after, croupous pneumonia
9. Mullanowski ..	M.	47	9 Aug., 1875	Carcinoma	Whole larynx	Recurrence and death two months after operation
10. Billroth ..	M.	54	11 Nov., 1875	Diffuse carcinoma	Whole larynx	Death on fourth day from bronchopneumonia
11. Maas ..	M.	50	5 Feb., 1876	Epithelioma	Whole larynx except part of cricoid and epiglottis	Death six months after from recurrence
12. Gerdes ..	M.	76	30 Mar., 1876	Carcinoma	Whole larynx	Death four days after from exhaustion
13. Keyher ..	M.	60	May, 1876	Carcinoma of the vocal cords	Whole larynx except epiglottis	Death eleventh day from pneumonia
14. Watson ..	F.	60	1876	Epithelioma; infected glands	Whole larynx and glands	Death, pulmonary embolus, seven days after
15. Kosinski ..	F.	36	15 Mar., 1877	Epithelioma	Whole larynx and epiglottis	Death from pneumonia nine months after
16. Wegner ..	F.	52	17 Sept., 1877	Carcinoma	Whole larynx and epiglottis	After eight months no return

17. Bottini ...	M.	48	29 Aug., 1877	Epithelioma	Whole larynx and part of oesophagus	Death third day from pneumonia
18. Von Bruns ...	M.	54	29 Jan., 1878	Epithelioma	Whole larynx	Death in nine months after recurrence
19. Billroth ...	F.	43	27 Feb., 1879	Epithelioma of larynx, pharynx, and thyroid	Whole larynx, part pharynx, and oesophagus	Death seven weeks after
20. Macewen ...	M.	56	31 July, 1879	Carcinoma of larynx, pharynx, and glands	Larynx, part pharynx, and glands	Death after three days from pneumonia
21. Von Langenbeck ...	M.	78	1879	Carcinoma	Whole larynx	Death three days, collapse
22. Multanowski ...	M.	60	4 Dec., 1879	Carcinoma	Larynx	Death in five days from pneumonia
23. Reyher ...	M.	48	1880	Carcinoma	Whole larynx	Death seventh day from broncho-pneumonia
24. Thiersch ...	M.	36	26 Feb., 1880	Carcinoma	Whole larynx and two rings of the trachea	No recurrence after eighteen months; death 19 August, 1882, after second operation for recurrence
25. Thiersch ...	M.	52	15 April, 1880	Carcinoma	Whole larynx	No recurrence after seventeen months; three and a-half years after was well
26. Czerny ...	M.	47	11 Oct., 1880	Epithelioma of larynx and soft parts	Larynx and soft parts	Death five months after from bleeding from the recurrence
27. Hahn ...	M.	68	23 Oct., 1880	Carcinoma	Whole larynx, part of thyroid cartilage, and the epiglottis	No recurrence after four years
28. Thiersch ...	F.	45	10 Nov., 1880	Carcinoma	Larynx and part of pharynx	Death one hundred and thirty-two days after operation

- 1 *Arch. für Klin. Chir.*, xvii., p. 343.
- 2 Böhm, *Correspondenzblatt*, 1874.
- 3 *Arch. für Klin. Chir.*, xix., S. 507.
- 4 *Arch. für Klin. Chir.*, xviii., S. 139.
- 5 Foulis, *loc. cit.*
- 6 *Berlin. Klin. Wochenschr.*, 1875.
- 7 *Berlin. Klin. Wochenschr.*, 1875, No. 33.
- 8 *Cent. für Chir.*, 1882, No. 25.
- 9 *Cent. für Chir.*, 1882, No. 25.
- 10 *Archiv für Klin. Chir.*, lxx., p. 25.
- 11 *Archiv für Klin. Chir.*, lxx., p. 25. (Zesas gives date 1874.)
- 12 *Archiv für Klin. Chir.*, lxx., p. 25. Three months after operation carcinoma of root of tongue, and patient declining operation. Six months later died from bleeding from the ulcers.
- 13 *Arch. für Klin. Chir.*, xxi.
- 14 *St. Petersburg Med. Wochenschr.*, 1877.
- 15 *Cent. für Chir.*, 1877, S. 401.
- 16 *Verhandlung der Deutschen Gesellsch. für Chir.*, 1878.
- 17 *Annales des Maladies de l'Oreille et du Larynx*, 1878.
- 18 *Wiener Med. Presse*, 1878. November 17.
- 19 Zesas gives Billroth, July, 1878. *Carcinoma* recurrence. *Deutsche Chir. Lief.*, S. 199, 370. *Archiv für Klin. Chir.*, lxx., p. 880.
- 20 Foulis' Table.
- 21 *Verhandl. der Deutschen Gesellschaft für Chir.*, Bd. x.
- 22 *Centralt. für Chir.*, 1882, No. 25, p. 420.
- 23 *Wolner's Medical Journal*, 1880. Cohen's *Statistics*.
- 24 *Deutsche Zeitschrift für Chir.*, Bd. xvi., S. 149. (Zesas says 26th January, 1880.)
- 25 *Cent. für Chir.*, 1882, No. 37. *Deutsche Zeitschr. für Chir.*, Bd. xvi., S. 149.
- 26 *Berlin. Klin. Woch.*, 1882, No. 26.
- 27 *Archiv. of Laryngology*, 1883.
- 28 *Cent. für Chir.*, 1883, No. 37. In extirpating a recurrently infected gland a piece of right carotid had to be removed. December 14, hemorrhage from lower carotid stump March 16, 1881 (132 days after), death from recurrent bleeding.

## TOTAL EXTIRPATION OF THE LARYNX.—I. FOR MALIGNANT DISEASE.—Continued.

Operator.	Sex.	Age.	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
29. Bircher ...	F.	49	3 Dec., 1880	Thyroid gland and larynx	Whole larynx and part of pharynx	Death sixteen days after from pneumonia
30. Pick ...	M.	39	16 Jan., 1881	Epithelioma	Whole larynx and part of pharynx	Death fifth day from pleuro-pericarditis
31. Thiersch ...	F.	57	17 Jan., 1881	Carcinoma of pharynx and larynx	Whole larynx and part of pharynx	Death seventh day from pneumonia
32. Toro ...	—	—	9 Mar., 1881	Epithelioma	Whole larynx and base of tongue	Death fourth day, emphysema pulmonum
33. Winwarter ...	F.	55	April, 1881	Carcinoma	Whole larynx	Patient well in July, 1884, three and a half years after
34. Foulis ...	M.	50	30 April, 1881	Epithelioma	Larynx	Death from recurrence ten months after
35. Czerny ...	M.	47	12 May, 1881	Epithelioma	Larynx and two upper rings of the trachea	Death fifth day from pneumonia
36. Keyher ...	M.	57	14 May, 1881	Carcinoma (?)	Whole larynx, except part of cricoid cartilage	Death in 1883 (two years after) of cancer of abdomen
37. Kocher ...	M.	59	16 May, 1881	Carcinoma (?)	Whole larynx	Death in thirty-six hours from collapse
38. Tilanus ...	M.	51	May, 1881	Epithelioma	Whole larynx	No recurrence after nineteen months.
39. Gussenbauer ...	M.	48	19 May, 1881	Epithelioma	Whole larynx	Still living (1886): communication from operator to Socin—Schwartz's tables
40. Voelker ...	F.	44	28 May, 1881	Carcinoma	Larynx	Death from recurrence after five months
41. Albert ...	M.	45	6 July, 1881	Carcinoma	Whole of larynx except epiglottis	Death eighth day from lobular and diffused broncho-pneumonia
42. Hahn ...	M.	46	13 Aug., 1881	Carcinoma	Whole larynx	Death on twenty-fifth day from putrid bronchitis
43. Marjary ...	F.	36	29 Sept., 1881	Epithelioma	Whole larynx, part of esophagus, and pharynx	Recurrence after three months
44. Gussenbauer ...	M.	62	Oct., 1881	Epithelioma	Whole larynx	No recurrence fourteen months after
45. Gussenbauer ...	M.	63	Oct., 1881	Carcinoma	Whole larynx	Recurrence in six months; nothing known

46. Keyher ...	M.	73	10 Oct., 1881	Carcinoma	Whole larynx and three tracheal rings	Death nine months after recurrence
47. Novaro ...	M.	63	19 Aug., 1880	Epithelioma	Whole larynx	Recurrence in four months. Second operation, 14 January, 1881; death eleventh day after operation from hemorrhage
48. Schede ...	M.	54	1881	Carcinoma	Whole larynx and thyroid gland	Recurrence after seven months, and death from suicide
49. Reyher ...	M.	55	7 April, 1882	Carcinoma and epithelioma	Whole larynx	Death fourteenth day after operation from exhaustion
50. Reyher ...	M.	65	10 Oct., 1881	Carcinoma	Whole larynx	Death seventh day after from septic pneumonia
51. Hohner ...	M.	57	15 Mar., 1882	Epithelioma	Larynx	Death seven months after from recurrence
52. Kocher ...	M.	54	13 May, 1882	Carcinoma	Larynx and glands	Recurrence seven months after in glands, but patient living sixteen months after the operation
53. Whitehead ...	M.	46	27 May, 1882	Epithelioma	Larynx, one tracheal ring without epiglottis	No recurrence after eight months
54. Von Bergmann ...	M.	54	12 June, 1882	Adeno-sarcoma (?), carcinoma (?)	Whole larynx	Recurrence in February, 1883; dead

- 29 *Trans. Int. Med. Congress*, 1881.  
30 *Lancet*, 1881, p. 541.  
31 *Deutsche Zeitschr. für Chir.*, 1882, Bd. xvi. Old abscess in the lungs.  
32 *Med. Record*, New York, 1881, August 6.  
33 *Clin. für Chir.*, 1882, No. 37. (On December 27, 1883, was completely well, according to Zesas.)  
34 *Trans. Int. Med. Congress*, London, 1881. In August, 1881, was still well and strong.  
35 *Cent. für Chir.*, 1882, No. 37. *Berlin. Klin. Woch.*, 1882, No. 26.  
36 *Trans. Int. Med. Congress*, 1881.  
37 *Archives of Laryngology*, New York, 1883. No recurrence after sixteen months, according to Cohen.  
38 *Cent. für Chir.*, 1882, No. 34. with no local recurrence (Schwartz).  
39 *Cent. für Chir.*, 1883, No. 45. Said by Gussenbauer to be well in 1886 (communication to Prof. Socin).  
40 Cohen's *Statistics and Academische Proveschen*, S. 84 112. Amsterdam, 1882.  
41 *Wiener Med. Press.*, 1873 and 1881.  
42 Cohen's *Statistics and Sammlung Klin. Vorträge*, No. 260, p. 5.  
43 *Archiv Ital. di Lar.*, 1882. Dead from hemorrhage, March 25, 1882.  
44 *Cent. für Chir.*, 1883, No. 45. One and three-quarter years after, completely well; said in 1886 to be still living (Schwartz's Tables).  
45 *Cent. für Chir.*, 1883. This is in Zesas' Table, but not in Hahn's.  
46 *St. Petersburg Med. Zeitsch.*, 1882, No. 28.  
47 *Archiv Ital. di Lar.*, 1882, Anno. i. p. 75.  
48 *Deutsch. Med. Woch.*, 1882.  
49 Cohen's *Statistics*. Letter from Prof. Burow.  
50 Cohen's *Statistics*. (This is in Zesas' but not in Hahn's Table.)  
51 *Hospitale Tidende*, Copenhagen, 1883. (In Hahn's but not in Zesas' Table.)  
52 Letter of Kocher to Solis-Cohen.  
53 *Lancet*, 1882, No. 4.  
54 *Cent. für Chir.*, 1882, No. 25.

TOTAL EXTIRPATION OF THE LARYNX.—I. FOR MALIGNANT DISEASE—*Continued.*

Operator.	Sex.	Age.	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
55. Burow ...	M.	44	25 July, 1882	Carcinoma	Larynx without epiglottitis	Dead four and a half months after from sudden suffocation
56. Holmer ...	M.	63	18 July, 1882	Epithelioma	Larynx and part of pharynx	Dead four months after from recurrence
57. Kocher ...	M.	43	28 Sept., 1882	Carcinoma	Larynx and part of œsophagus	Living still (?)
58. Mayall ...	M.	50	31 Aug., 1882	Carcinoma	Whole larynx except cricoid	Was well in 1883
59. Lücke ...	F.	54	28 July, 1883	Carcinoma	Whole larynx	Dead four months after from pneumonia; no recurrence
60. Leisrink ...	M.	72	8 Aug., 1883	Carcinoma	Whole larynx	Death fourth day of pneumonia
61. Mayall ...	F.	45	1883	Carcinoma	Whole larynx	Death five weeks from purulent bronchitis and tracheitis
62. Von Bergmann ...	M.	—	1883	Carcinoma	Whole larynx	Dead 10th April, 1885, with recurrence
63. Hahn ...	M.	58	18 Oct., 1883	Carcinoma	Whole larynx and epiglottitis	Dead fourth day of pneumonia
64. Hahn ...	M.	43	11 Feb., 1884	Carcinoma	Whole larynx	Death fourth day of pneumonia
65. Vogt ...	F.	29	Feb., 1884	Carcinoma	Thyroid cartilage and epiglottitis	Dead fourth day of pneumonia
66. Hahn ...	M.	53	12 Oct., 1884	Carcinoma	Whole larynx and part of œsophagus	Dead fourth day of pneumonia
67. Hahn ...	F.	52	8 Nov., 1884	Carcinoma	Whole larynx and part of œsophagus	Lived three months; death afterwards from recurrence
68. Novaro ...	M.	68	Jan., 1882	Carcinoma (?)	Whole larynx and upper rings of trachea	Sudden death 8th March, 1882, without recurrence
69. Novaro ...	M.	52	26 July, 1882	Carcinoma	Whole larynx	Living on 7th October, 1884, without trace of recurrence
70. Novaro ...	M.	72	18 Aug., 1882	Carcinoma	Whole larynx	Death suddenly, from suffocation, 19th April, 1883; a feather found in trachea, used to clean cannula; no trace of recurrence
71. Winawarter ...	M.	46	Sept., 1882	Carcinoma	Whole larynx except cricoid	Recurrence in April, 1883 (seven months after)
72. Winawarter ...	M.	50	Oct., 1882	Carcinoma	Whololarynx, part pharynx, many lymph glands; resection internal jugular vein	Death ninth week from inanition



73. Gussenbauer	...	M.	63	6 Feb., 1883	Epithelioma	Whole larynx, keeping epiglottis and mucosa in relation with ary-epiglottic folds	Well six months after operation; in 1886 was still living: communication to Socin—Schwartz's tables
74. Pretorius	...	F.	54	23 July, 1883	Epithelioma	Larynx, except inferior half of cricoid	No recurrence in November, 1883; living in November, 1885
75. Novaro	...	M.	54	1 Oct., 1883	Epithelioma	Larynx, thyroid gland, and part of pharynx	Death one month after from croupous pneumonia
76. Kocher	...	—	—	1883	Carcinoma	Larynx	Patient lived without local recurrence in 1884, but with glands invaded
77. Jones, Th.	...	M.	43	26 April, 1884	Lobulated epithelioma	Whole larynx, first ring of trachea, part of pharynx	Well on 14 June, 1884, one month and a half after operation
78. Holmes	...	M.	63	26 May, 1884	Epithelioma	Whole larynx, except left half of cricoid; resection of pharynx	Death from collapse in forty hours
79. Durante	...	—	—	1884	Carcinoma	Larynx	Death in two or three days
80. Jordan Lloyd	...	M.	51	1884	—	Larynx	Death from pneumonia six days after
81. Von Bergmann	...	M.	46	1885	Epithelioma	Larynx with epiglottis	Six weeks after, cured
82. Park	...	M.	—	28 June, 1885	Epithelioma	Whole larynx	Six months after operation cured, and speaking with artificial larynx
83. Péan	...	M.	35	27 Feb., 1886	Pavement epithelioma	Whole larynx except epiglottis	Cured
84. Labbé	...	M.	51	Feb., 1886	Lobular epithelioma	Whole larynx except part of cricoid	Death fourteenth day from broncho-pneumonia

- 55 *Cent. für Chir.*, 1882, and *Archives of Laryngology*, 1883.  
56 *Hospitals-Tidende*, 1883.  
57 *Sammlung Klin. Vorträge*, No. 224, S. 1944.  
58 *Wiener Med. Presse*, 1882, No. 53, and *Centralbl. für Chir.*, 1883, No. 9, S. 141.  
59 *Deutsche Zeit. f. Chir.*, Bd. xix., S. 622.  
60 *Berlin. Klin. Woch.*, February 4, 1884.  
61 *Wiener Med. Presse*, 1884, No. 12.  
62 In *Vessas' Table in Arch. für Klin. Chir.*, Bd. xxx., H. 3, 1884  
63 *Sammlung Klin. Vorträge*, 260, No. 82.  
64 *Ibid.*  
65 *Mittheilungen aus der Chirurgischen Klinik zu Greifswald*  
66 *Sammlung Klin. Vorträge*, loc. cit.  
67 *Ibid.*  
68 Letter from Massei to Cohen, 1884.  
69 Letter of Massei to Solis-Cohen, 1884 (Schwartz's Tables).
- 70 *Ibid.*  
71 Letter to Solis-Cohen (Schwartz's tables).  
72 *Ibid.*  
73 *Prager Med. Woch.*, 1883, No. 34.  
74 *Deutsche Zeit. für Chir.*, Bd. xix., S. 621.  
75 *Gaz. des. Hosp.*, December 9, 1883.  
76 Letter from Kocher to Solis-Cohen (Schwartz Tables  
77 *Lancet*, August 2, 1884, p. 192.  
78 *Brit. Med. Journ.*, October 25, 1884.  
79 Letter of Massei to Solis-Cohen, September 10, 1884 (Schwartz's Tables)  
80 *Lancet*, November 29, 1884.  
81 *Petersburger Mediz. Woch.*, 1885, No. 27.  
82 *Brit. Med. Journ.*, October 24, 1885.  
83 *Gaz. Méd. de Paris*, April 17, 1886.  
84 Schwartz's Tables.

TOTAL EXTIRPATION OF THE LARYNX.—I. FOR MALIGNANT DISEASE—*Continued.*

Operator.	Sex.	Age.	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
85. Lalbé ...	M.	50	31 March, 1886	Lobular epithelioma with invasion of tracheal rings Carcinoma	Total extirpation of larynx with one tracheal ring	On May 20, well; four and a half months after, recurrence and death
86. Mickulicz	—	—	—	—	Whole larynx	Death from inanition some months after, deglutition not having been re-established
87. Mickulicz	—	—	1886	Carcinoma	Whole larynx	Cure dating from some weeks
88. Axel Iversen	F.	44	3 Aug., 1883	Pharyngo-laryngeal carcinoma	Total ablation with part of pharynx and oesophagus	Death three months after; no recurrence, but septicaemia consequent upon operation to enlarge the oesophago-tracheal infundibulum
89. Axel Iversen	M.	48	12 Aug., 1884	Epithelioma of pharynx and larynx	Total ablation with part of pharynx	Three and a half months after the operation was well.
90. Kosinski	M.	62	19 Nov., 1886	Carcinoma keratoides	Total ablation	Death eight weeks later of pneumonia.
91. Péan ...	M.	65	6 March, 1886	Epithelioma	Total ablation, leaving cricoid cartilage	Patient died from broncho-pneumonia by introduction of oesophageal sound into trachea
92. Newman	M.	37	1 Feb., 1886	Epithelioma	Whole larynx	Six months after, no recurrence
93. Gardner	—	—	—	Epithelioma	—	Patient alive four months after
94. Högden	—	—	—	—	Whole larynx with epiglottitis	Death in four days
95. Lange ...	F.	30	11 July, 1884	Carcinoma	Whole larynx with epiglottitis and cricoid cartilage	Death on fifth day from septicaemia
96. Billroth ...	M.	60	29 Nov., 1879	Carcinoma	Total extirpation with part of trachea and epiglottitis	Death from pneumonia three days after
97. Billroth ...	M.	26	14 Sept., 1880	Epithelioma	Total extirpation with first ring of trachea	Death from hemorrhage eighth day after
98. Billroth ...	—	—	1887	Carcinoma	Total extirpation	Death same night; no lesion found post-mortem; probably syncope
99. Dupont	M.	52	19 Oct., 1886	Carcinoma	Total extirpation	Alive 26 February, 1887
100. Stelzner ...	M.	—	9 Feb., 1887	Carcinoma	Total extirpation	Alive 12 March, 1887
101. Novaro ...	M.	41	3 March, 1887	Epithelioma	Total extirpation	Alive June, 1887
102. Novaro ...	M.	72	14 July, 1887	Epithelioma	Total extirpation	Alive August, 1887
103. Von Bergmann...	—	—	15 Nov., 1887	Carcinoma	Total extirpation	Death

TOTAL EXTIRPATION.—II. FOR SARCOMA.

Operator.	Sex.	Age.	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
1. Bottini ...	M.	24	6 Feb., 1875	Round and spindle-celled sarcoma	Whole larynx	On 7 October, 1884 (ten years after), patient was quite well
2. Foulis ...	M.	28	10 Sept., 1877	Spindle-celled sarcoma	Whole larynx, except superior cornua of thyroid cartilage and half the arytenoids	Died of tracheal and pulmonary phthisis on 1 March, 1879
3. Czerny ...	M.	46	24 Aug., 1878	Lympho-sarcoma, with glandular invasion	Whole larynx and glands	Dead after five operations for recurrence fifteen months after
4. Caselli Azzio ...	F.	19	20 Sept., 1878	Sarcoma, larynx, pharynx, palate, and base of tongue	All these parts with tonsils	Well on 19 April, 1881
5. Lange ...	M.	74	12 Oct., 1879	Sarcoma of larynx and pharynx	Larynx, right cornu, hyoid bone, and part of oesophagus	Dead seven months after of ashenia ; recurrence
6. MacLeod ...	M.	54	19 Sept., 1883	Sarcoma	Whole larynx, with a tumour of the pharynx, and thyroid and indurated glands	Death on fifth day from secondary hemorrhage
7. Hahn ...	M.	43	17 May, 1885	Sarcoma	Larynx and epiglottis	Since dead of recurrence
8. Labbe and Cadier ...	M.	59	12 Mar., 1885	Fasciculated sarcoma	Whole larynx, except part of cricoid cartilage	Dead of pneumonia on 6 June, 1885

1 *Giornal della R. Acad. di Torino*, May 20, 1875, No. 14.

2 *Lancet*, October 13, 1877, and March 29, 1879.

3 *Beichn Klin. Woch.*, June 27 and July 3, 1882.

4 *Bol. del Scienze. Med. Bologna*, t. iv., 1886, and 11 *Raccogliatore Medico*, p. 321, October, 1879.

5 *Archives of Laryngology*, New York, vol. i., p. 36.

6 *Lancet*, April 26, 1884, p. 750.

7 *Sammlung Klin. Vorträge*, No. 260, p. 16.

8 *Annales des Mal. de l'Oreille et du Larynx*, 1885, p. 100.

85 Schwartz's Tables.  
86 Communication from Prof. Socin. Schwartz's Tables.

87 *Ibid.*  
88 *Archiv für Klin. Chir.*, 1885, Bd. xxxi., p. 647.

89 *Ibid.* p. 656, 1885.  
90 *Gazeta Lekarska*, 1886, No. 17 and 18.

91 *Gaz. Méd. de Paris*, April 17, 1886.  
92 *Lancet*, July 24, 1886.

93 *Lancet*, May 7, 1887.  
94 *Ibid.*

95 *Annals of Surgery*, 1886, vol. iii.

96 Salzer, *Archiv für Klin. Chir.*, Bd. xxxi., p. 879.

97 *Ibid.*  
98 Private communication.

99 *La Pratique Médicale*, November 22, 1887.

100 *Ibid.*

101 *Ibid.*

102 *Ibid.*

103 *Ibid.*

## TOTAL EXTIRPATION.—III. FOR OTHER CONDITIONS.

Operator.	Sex.	Age	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
1. P. H. Watson	M.	36	1866	Syphilitic stenosis	Whole larynx and upper tracheal ring	Death from pneumonia three weeks after
2. Rubio	M.	41	11 May, 1878	Perichondritis and necrosis of thyroid cartilage	Whole larynx	Died on fifth day, of marasmus
3. Gussenbauer	M.	24	24 May, 1879	Laryngeal tuberculosis	Whole larynx	Death two months after from pulmonary tuberculosis
4. Ruggi	M.	10	1882	Laryngeal papilloma	Whole larynx	Alive on 7 October, 1884
5. MacLeod	M.	35	1882	Laryngeal papilloma	Whole larynx and thyroid gland	Died five months after of pulmonary tuberculosis.
6. Jordan Lloyd	—	—	1886	Laryngeal phthisis	Whole larynx	Death six days after operation, of purulent bronchitis—lungs full of milary tubercles.

<sup>1</sup> Table of Fouths.<sup>2</sup> *Observari clinica, Real Academia de Med. Madrid*, 1878.<sup>3</sup> *Prag. Med. Woch.*, 1883, No. 31—34.<sup>4</sup> *Racogilldove Med.*, 1882, xviii, p. 36, and *Centr. für Chir.*, 1882, No. 45.<sup>5</sup> *Ind. Med. Gaz.*, vol. xviii, p. 24, 26, 1883, *Lancet*, September 15, 1883.<sup>6</sup> *Lancet*, January 15, 1887.

Of these one hundred and three cases for carcinoma, at least forty may be said to have died from the immediate effects of the operation, within a period varying from a few hours (collapse) to eight weeks. In this number we include one case which lived for seven months, eventually dying from inanition from impossibility of deglutition from the first. Twenty-one of these cases are recorded to have died from pneumonia, four from collapse, two from exhaustion, others from pleuro-pericarditis, emphysema, putrid bronchitis, septicæmia, hæmorrhage, &c.

One of Thiersch's cases, the shortest time being in two months, the average being about six months, abdominal cancer two years after.

SUCCESSFUL CASES.—Since tracheotomy alone will add an average period of twelve months to a patient's life, we do not consider that we are entitled to regard extirpation of the larynx as successful unless a patient survives six months has been added by the operation to the patient's existence.

Of the total number of recorded cases only nine are certainly recorded to have been living twelve months after the operation. These are as follows:—

1. THIERSCH : No recurrence eighteen months after.
2. THIERSCH : No recurrence seventeen months after.
3. NOVARO : Patient alive two and a half years after, without recurrence.
4. KOCHER : Patient lived two years, dying of abdominal cancer.
5. WINIWARTER : Patient alive three and a half years after.
6. HAHN : Patient alive four years after.
7. GUSSENBAUER : Patient living in 1886, five years after.
8. GUSSENBAUER : Patient without recurrence fourteen months after.
9. GUSSENBAUER : Patient alive three years after.

Eight total extirpations have been done for sarcoma : of these, four lived over twelve months, one dying eighteen months after the operation, one having submitted to five intermediate operations (Czerny), and dying fifteen months after the primary operation. One was reported still living two and a half years after the operation (Casselli), and one was said, in 1884, ten years after the operation, to be alive and well (Bottini).

Six total extirpations have been done for other conditions, of which five were followed by death within five months. One operation performed by Ruggi was successful, the patient being alive two years after. This operation was remarkable as having been performed on a boy of ten years of age, and further for the cause, which was laryngeal papillomata.

Total extirpation has thus been performed as follows :—

For carcinoma	...	...	...	...	103	times.
„ sarcoma	...	...	...	...	8	„
„ other causes	...	...	...	...	6	„

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Making a total of     ...     ...     117     „

Only twelve of which (or about 10 per cent.) have lived twelve months after the operation. A few cases are not included of which nothing has been recorded or the subsequent history of which has not been traced further than a few months after the operation.

In the three successful cases of Gussenbauer a microscopic diagnosis was made of epithelioma, but the lesion was circumscribed and developing slowly.

*(To be continued.)*



## NOSE AND NASO-PHARYNX.

**FIRIVE** (Christiania).—**Blennorrhœa Nasi.** *Berlin. Klin. Wochenschr.*, 1887, No. 35.

PURULENT secretions arise in the nose from foreign bodies, affections of the bones, empyema of the antrum of Highmore or of the frontal sinus. MICHAEL.

**ISCH-WALL.**—On the Erectile Tissue of the Nasal Fossæ. *Progrès Médical*, September 10, 1887.

AFTER speaking of the works of Zuckerkandl, Hack, and John Mackenzie, the author says that the erectile tissue of the nasal cavities is primarily constituted of capillaries, which later on show considerable development and important modifications. The mucous membranes of a certain number of embryonic mammals have been examined, preparations of the nasal mucosa of the fœtus of pigs, cats, wolves, rats, and men having been made, and in all a fairly abundant capillary network has been found. The nearer the fœtus approaches the moment of birth, the more these capillaries are developed. The author has also examined the mucosa of adult animals. In man, on cutting across the middle turbinated body he saw at first rather large gaps in the spongy tissue of the bone; the chorion is also occupied by dilated spaces larger in proportion to their proximity to the deep layer of mucosa, where their volume is considerable. On the broad margin of the mucosa, under the epithelium, are found large dilated spaces, whilst in the deeper parts abundant veins are seen. This tissue is, then, primarily formed of capillaries, which expand enormously in the process of development, and are transformed into cavernous organs susceptible of erection.

The author then commences the study of pathological and physiological facts (borrowing the greater number from the works of John Mackenzie) to show how close the relations are between the erectile tissue of the nose and the generative organs, and concludes thus:—The cavernous tissue of the nose is the starting-point of certain reflexes, notably of erection in a good number of cases; on the other hand, genital erection reacts on it, making it turgid. JOAL.

**SOTA Y LASTRA.**—Foreign Bodies in the Nasal Fossæ. *Revista Médica de Sevilla*, September 30, 1887.

THE author refers to five cases in his own practice; the first one of a hair-pin, in the left nasal fossa, which had necessarily to be drawn out through the mouth by means of the naso-pharyngeal polypus forceps; the second one of a leech, adherent to the posterior

surface of the middle turbinated bone of the right side, which was drawn out through the anterior opening of the nose by means of nasal polypus forceps; the third of a chickpea, lodged in the left nasal fossa, which was broken and drawn out in pieces with forceps; the fourth of a piece of sponge, in the right nasal fossa, which was spontaneously expelled; the fifth of the calix of a rose, in the left nasal fossa, which was drawn out by means of a small ivory spoon of the kind used to clean the auricles. SOTA Y LASTRA.

**RUAULT, A.**—On the Employment of Cocaine as a Hæmostatic in the Treatment of Epistaxis, and in Rhino-surgery. *France Médicale*, October 1, 1887.

COCAINE is not merely a local anæsthetic, but also a local vaso-constrictor, for the lessening in volume of the nasal mucous membrane produced by this agent is owing to the rapid depletion of the submucous erectile tissue. These two properties of cocaine are independent of one another; the disappearance of sensibility is not due to local anæmia, since tissues deprived of vessels—*e.g.*, the turbinated bodies—are rendered anæsthetic with the greatest ease. The vaso-constrictor result is not due to direct action on the vessels; Bosworth has noticed that this action is confined to the venous sinuses, and does not extend to the capillaries. Indeed, cocaine does not make the nasal mucosa any paler than before the application, and it is therefore probable that this loss of blood is due to a reflex action making itself felt on the small arteries and the smooth fibres of the erectile tissue. Ruault has employed cocaine for two years as a hæmostatic, and uses solutions of 20 per cent. to 30 per cent.; he soaks a plug of cotton-wool in the fluid, and leaves it in the nasal cavities for at least nine minutes. In spontaneous epistaxis the plug should be left in for two or three hours. The author has stopped thus a certain number of hæmorrhages: one of the patients had been obliged previously to submit to tampons. The use of cocaine also arrests the hæmorrhage following nasal operations, *e.g.*, ablation of polypi. JOAL.

**ZIEM** (Dantzig).—On Post-nasal Operations under the Guidance of the Finger. *Monatsschr. für Ohrenheilk., etc.*, 1887, No. 9.

A VERY well written apology for pharyngoscopical operations under the guidance of the finger instead of the rhinoscope. It is simpler and easier to operate in this manner, and the application of the galvano-caustic wire to the hinder part of the nasal conchæ can especially be more easily performed, as a case of the author proves. Other operators have also occasionally adopted this method, but it is worthy of more frequent application. MICHAEL.

**UCHERMANN, V.** (Christiania).—**Adenoid Vegetations.** *Norsk Magazin for Læger, November, 1887.*

AFTER a short review of the pathology and treatment of adenoid vegetations, the author quotes several cases, amongst others a case of a child, aged four, with hereditary syphilis, upon whom he operated for adenoid vegetations, and another case in which an adenoid growth was situated on the Eustachian tube.

HOLGER MYGIND.

**SCHECH** (München).—**On Asthma.** *Münchener Med. Wochenschr.*, 1887, Nos. 40, 41.

THE author found diseases of the nose in 64 per cent. of his cases of asthma. If disease of the nerves could cause asthma, it must be combined with unusual irritability of the nerves. It may be caused by irritation of the olfactory nerve, but more often of the trigeminal nerve from contact of such parts of the nose as, normally, are not in contact with each other. It may be caused also by psychical irritation, as in the well-known case of John Mackenzie (an artificial rose). The nasal therapeusis of asthma owes its effect to the removal of the abnormal contact of parts of the nose, and the restitution of normal circulation. The real nature of asthma is a spasm of the bronchial muscles. The spirals of Curschman and the crystals of Leyden are not the cause, but the effect of asthma.

MICHAEL.

## TONSILS, PHARYNX, &c.

**SANDERSON, —.** (Sussex).—**Pulsating Vessel in the Pharynx.** *British Medical Journal, September 17, 1887.*

CASE of a lady, aged sixty, in whom a pulsating vessel the size of a crow quill could be seen and felt between the posterior faucial pillar on the right side, and the posterior wall of the pharynx. The patient suffered from catarrh of the throat and nose. There were no enlarged glands in the neck, as had been found in some cases by Farlow.

HUNTER MACKENZIE.

**WALKER-DOWNIE** (Glasgow). — **Dryness of the Throat from Excessive Tea-drinking.** *Practitioner, October, 1887.*

THE author, three years ago, pointed out that cheap, inferior tea, literally *steved*, and partaken of with every meal, by the lower class of patients, was a potent factor in the production of dry pharyngitis. Under chalybeate treatment (such patients being anæmic and badly fed) and the liberal use of farinaceous food and milk, the patients

rapidly recovered. Change of diet alone is sufficient to cure the condition.

This form of dry pharyngitis (not involving the naso-pharynx) is in great measure due to the dyspepsia caused from drinking stewed tea before, with, or after meals, and also to the local astringent and irritant effect. Total abstinence from tea should be rigorously enjoined.

**BENDER** (Bonn).—On Lichen Ruber of the Skin and Mucous Membranes. *Deutsche Med. Wochenschr.*, 1887, No. 39.

IN two cases of this disease the author saw a continuation of the exanthem on to the mucous membrane of the mouth. On the palate were little white tubercles, and on the back of the tongue white plaques. Small tubercles were also visible on the pharynx and its lateral walls.

MICHAEL.

**WILLETT, GEORGE, G. D.** (Bristol).—Retro-pharyngeal Abscess. *British Medical Journal*, October 8, 1887.

A SHORT note descriptive of the case of a man aged fifty, who had complained for some weeks of dysphagia. He died suddenly after admission to the Bristol Royal Infirmary. *Post-mortem* examination revealed a retro-pharyngeal abscess, with a sac nine inches long, and containing a pint of thick, curdy pus. No eroded or bare bone was felt.

HUNTER MACKENZIE.

**ALSBERG** (Hamburg).—Artificial Teeth in the Œsophagus: Œsophagotomy—Cure. *Deutsche Med. Wochenschr.*, 1887, No. 39.

THE teeth could not be removed *per vias naturales*; œsophagotomy was therefore performed the same day. After the incision it was not possible to remove the teeth through the wound, but it was practicable to make them movable, and to extract them through the mouth. The foreign body was a palate with six teeth. The wound in the œsophagus was sewn up, and the skin-wound dressed with iodoform gauze and closed on the tenth day.

MICHAEL.

## LARYNX.

**BARRON, B. J.** (Bristol).—Hoarseness and Loss of Voice. *Bristol Med. Chir. Journal*, September, 1887.

THE author's cases have fallen under the following heads:—Chronic laryngitis, hysteria, laryngeal phthisis, laryngeal anæmia, acute laryngitis, laryngeal syphilis, growths in the larynx, aneurism, œdema of the larynx.



The author relies upon brushing the larynx with chloride of zinc (xv.—xxx. gr. ad 3j. glycerine) in chronic laryngitis, with rest of voice, and avoidance of all irritants. He finds 10 per cent. solution of cocaine in glycerine of borax most useful as a local application for the dysphagia of laryngeal phthisis. For ulcerations he prefers iodoform, and inhalations of creosote and terebene. He has not derived much benefit from menthol (20 per cent. in olive oil), but speaks well of lactic acid, which, however, is apt to cause spasm of the glottis. In one case of necrosis of the right arytenoid cartilage he was able to cure by clearing out the *débris* and stuffing the ulcer with iodoform. The author has seen cases of secondary syphilis of the pharynx associated with an obstinate erythematous laryngeal blush. He has observed gummata on the epiglottis go through stages of deposition, softening, and ulceration. Cocaine was proved to be a better anæsthetic than morphia. The author has observed papillomata diminish in size under applications of lactic acid and chloride of zinc.

Two cases of œdema of the larynx have occurred in the author's practice: one was very acute, voice being lost in an hour or two from the onset; only the epiglottis was affected, and the patient got well under benzoin and hot steam inhalations. The other case of subglottic and glottic œdema recovered under iodide of potassium.

**MOURE.**—*Remarks on Affections of the Vocal Organs in Catarrhal Laryngitis.* *Rev. Mens. de Laryngologie, etc., October, 1887.*

THE opinion generally accepted to explain vocal troubles in the course of acute catarrhal laryngitis is the existence either of material injuries hindering the functions of the vocal cords, or of muscular trouble caused by inflammation of the subjacent mucosa; this trouble would specially manifest itself on the side of the vocal cords, hindering their tension and their complete juxtaposition at the moment of emitting sound. Ziemssen, Solis Cohen, Lennox Browne, Gerhardt, Morell Mackenzie admit these muscular troubles; Moure also adopts this theory, making the thyro-arytenoid muscle alone play an important part, but attaching the greatest importance to the ary-arytenoid, which, on account of its larger surface, is more exposed than any other when the vocal mucosa is attacked with acute inflammation.

The isolated paralysis of this muscle causes complete aphonia, and its slight paralysis causes a hoarseness more or less pronounced, not only of the voice but also of the cough, which takes a croupal tone; it is thus easy to understand the modifications of the voice in acute laryngitis. The rapid alternations of the voice from deep to shrill are explained by the unequal contractions of the muscular fibres of



the transverse arytenoid ; if the muscle is partly relaxed, sound is extinguished, muffled or hoarse, and if it contracts quickly the vocal cords, during this exaggerated effort, give rise to a voice out of tune, and the note sounds harsh and grating. Irregular contraction of the vocal cords produces, on the contrary, a deep, hoarse, croaking voice. With children, hoarse, croupal cough is due to the inflammation of the arytenoid mucous membrane. The spasm and fit of suffocation are brought on by the spasmodic obliteration of the inter-cartilaginous glottis.

JOAL.

**ARIZA** (Barcelona).—**Laryngeal Tuberculosis.** *Revista de Laringología, Otología, y Rinología, August, 1887.*

OUT of twenty phthisical patients seen by Ariza during the term 1885-1886, in the *Instituto de Terapéutica Operatoria de Madrid*, sixteen were men and four women ; their ages ranged between sixteen and sixty-four years. The etiological causes were unknown, but in nearly all the cases there was some pathological relation between the larynx and the lungs. The cause of the affection was always chronic in the first-named organ, while chronicism and acuteness varied in the lungs. Ariza maintains the curability of laryngeal tuberculosis when the lung is sound or only slightly affected, though the lesions of the larynx may compel tracheotomy ; and he records the case of a lady patient who, after having been tracheotomized, had an absorptive fever, with copious sweating, purulent expectoration with detritus of the tissues, and pieces of necrosed cartilage, until a time arrived at which the elimination of the tuberculous engorgements ended, and the patient was cured of her laryngitis. The forms of tuberculosis observed in the twenty patients were the hypertrophic, the polypous, and the ulcerative. The treatment consisted in touching the ulcers with iodoform, carbolized and boric solutions, as well as with lactic acid and nitrate of silver ; in removing the pediculated polypi, and in cauterizing the sessile ones with chromic acid or galvano-cautery, and using for hypertrophies galvano-caustic punctures.

SOTA Y LASTRA.

**SOTA Y LASTRA.**—**Hæmorrhagic Laryngitis.** *Revista Médica de Sevilla, July 15, 1887.*

THE author records a case of a woman, in the state of pregnancy, who, after having washed her linen with very cold water, became hoarse, began to feel dryness and heat in her throat, and some trouble in swallowing, coughed often and expectorated blood. On examining her throat, the pharynx was found to be congested, and granular ; the velum, faucial pillars and the uvula were red, and the mucous membrane of the larynx was tumid and covered with

blood. On removing this, a small drop of the size of a pin's head appeared at the vertex of the right arytenoid. Every time it was cleared another new drop made its appearance. This woman was perfectly sound, no other of her organs offering the least symptom of disease. With the use of astringent medicines, applied both topically and internally, a cure was obtained at the end of three days.

SOTA Y LASTRA.

**ARIZA.**—**Extensive Laryngeal Papillomata; Complete Obstruction of the Glottis; Tracheotomy; Cure.** *Revista de Medicina y Cirugía Prácticas*, August 7, 1887.

THE author refers to the history of a young lady who, feeling somewhat heated, drank some cold water, from which moment she became hoarse and dyspnoic; the latter affection increasing until the point of requiring tracheotomy, which was performed by Dr. Rubio. After a few months Ariza examined her, finding in the bottom of her laryngeal vestibule a tumour of the size of a walnut, with a rough surface, granular, and slightly whitish; this completely filled the laryngeal cavity, and the author thinking it to be a papilloma removed it by avulsion, but in spite of the use of cocaine the patient's want of endurance enforced him to employ the cautery in order to destroy the remnants of the neoplasm. This, however, was not efficacious and produced some damage to the sound tissues; for this reason Ariza recurred to Voltolini's sponge method, meeting with good success. But the neoplasm was reproduced in the form of granulations, which grew on all sides. They were treated with the chloride of zinc solutions (50, 60, and 80 per cent.), and the sponges were often introduced. In this manner the disease was mastered; and after four months the patient was discharged with a regular and clean glottis, and the vocal cords free from papillomata.

SOTA Y LASTRA.

**SCHRAKAMP** (Stuttgart).—**Three Rare Cases of Tracheotomy.** *Berlin. Klin. Wochenschr.*, 1887, No. 35.

1. Tracheotomy for chronic laryngitis with acute dyspnoea.
2. Tracheotomy for a foreign body.
3. Tracheotomy for a retro-pharyngeal abscess.

MICHAEL.

**POLLARD, BILTON** (London).—**Tracheal Catheters.** *British Medical Journal*, September 17, 1887.

REPLYING to a note of inquiry, the author states that a tracheal catheter resembles a gum elastic catheter (urethral), but differs from it in being open at both ends like the supply tube of a stomach pump. They are supplied by Messrs. Krohne & Sesemann, London. See article on "Tracheal Catheterism" by Macewen, Glasgow, in Heath's *Dictionary of Practical Surgery*. HUNTER MACKENZIE.

## NECK, &c.

**WOLF, JULIUS** (Berlin).—Contribution to the Surgery of Goître. *Berl. Klin. Wochenschr.*, Nos. 27, 28, 1887.

REVIEW of the literature of the subject, and recommendation of partial extirpation, with illustrative cases. MICHAEL.

**D'ESTREËS DEBOUT**.—On Parotidean Gout. *Journ. de Méd.*, June 26, 1887.

THE author publishes thirteen observations on this gouty manifestation, and concludes: 1. That the existence of gout of the glands, and particularly of the parotid, is clearly demonstrated. 2. That contrary to the opinions he had expressed in 1885 at the Academy, glandular manifestations do not always alternate with articular. 3. That gouty parotiditis never ends in suppuration, but in the elimination of saliva charged with urates. JOAL.

**FAUVEL**.—Contribution to the Study of Dermoid Cysts of the Neck. *Thèse, Paris*, 1887.

CONGENITAL dermoid cysts are found in the thyroid space at the level of the third bronchial cleft, and result from the embryonic inclusion of a portion of the external integument. They coincide sometimes with other abnormalities of development. These cysts own heredity as a primordial factor. Extirpation is the only method of treatment which prevents any recurrence, and it is necessary to practise it as soon as one is sure of the dermoid nature of the cyst. JOAL.

**DELOBEL**.—Contribution to the Study of Chronic Abscess of the Sub-hyoid Region. *Thèse, Paris*, 1887.

THERE exists a prelaryngeal gland in front of the crico-thyroid membrane, in the V formed by the crico-thyroid muscles (Poirier's gland). Chronic abscesses of this region are superficial, or deep and of glandular origin. Chronic affections of the larynx or cartilages also produce deep abscess, or adenitis. The former are to be treated by incision and scraping, or successive punctures, followed by injection of iodoform in ether. The latter may be opened, to give outlet to the pus, but it will be necessary, almost always, sooner or later to perform tracheotomy. They may be scraped, but the production of a lesion of the subjacent parts must be avoided. It may lead to fistula of the larynx and trachea. JOAL.

**MOBITZ** (St. Petersburg).—Unilateral Fistula Colli Congenita Completa. *Petersburg Med. Wochenschr.*, 1887, No. 37.

A TUMOUR as large as an egg between the sternal portions of the

sterno-cleido-mastoidens and the windpipe was diagnosed as a fistula. It had a small opening through which a viscid fluid exuded on pressure. The emptied tumour filled again in twenty-four hours. The fistula was demonstrated by a probe. Treatment remained without effect.

MICHAEL.

**DESPRÈS.**—Cancer of the Tongue. Ablation of the Tongue with the Ecraseur. Previous Ligature of both Linguals. *Gaz. des Hôp.*, September 1, 1887.

A SUCCESSFUL case in a patient of forty-three operated on on February 9, and on May 25 quite cured. This method of operating obviates the usual troublesome hæmorrhage which follows even after ligature of the linguals below the digastric muscle. JOAL.

**PEL.**—A Case of Hemiatrophy of the Tongue, Paralysis of the left part of the Palate. Atrophy of the left Sternocleidomastoid, and Trapezius Muscles, and Paralysis of the Left Recurrent Nerve. *Berl. Klin. Wochenschr.*, No. 29, 1887.

CASE combined with bulbar paralysis in a patient of thirty-four years of age.

MICHAEL.

**HUGHES, ALFRED W. (Flint).**—Transient Localized Œdema of the Lip. *British Medical Journal*, September 24, 1887.

THE swelling occurred on one side of the lower lip, and is explained by the author as being most likely due to pressure on the veins of the part during sleep. A chronically enlarged gland situated on the same side of the face near the anterior margin of the masseter muscle, probably played some part in its production. On a previous occasion the swelling had come on during the night, and spontaneously disappeared during the following day, and a similar result was anticipated on this occasion.

HUNTER MACKENZIE.

**WILDE, R. G. (Hackney).**—Localized Facial Sweating. *British Medical Journal*, September 24, 1887.

THIS occurred in a patient who, many years ago, had suppuration of the parotid, following typhus fever. The sweating occurs on a patch about an inch in diameter, in the middle of the left cheek, invariably during mastication, or when any acid substance is taken into the mouth. There is no loss of power or sensation in the part; the sweating has lasted over twenty years.

HUNTER MACKENZIE.

**PHILLIPS, SIDNEY (London).**—Pulsating Aorta. *British Medical Journal*, October 8, 1887.

AMONGST the minor symptoms associated with pulsating aorta are dryness of the mouth, tongue, and palate. The dryness of the mouth



is generally much complained of. The tongue is usually covered with a dry white fur, and the papillæ are prominent. The author considers the dryness of the mouth (and dilatation of the pupil) an evidence of some irritation of the cervical sympathetic.

HUNTER MACKENZIE.

**JESSOP, CHARLES MOORE** (London).—**Ancient Dress compared with Modern in Relation to Disease.** *British Medical Journal*, September 17, 1887.

AN interesting historical and critical *résumé*. Amongst other subjects the author refers to the subject of “stays,” with special reference to their deforming effects upon the figures of their wearers, and their interference with the healthy action of the thoracic and abdominal viscera. The article will repay perusal by the medical practitioner. (See also leading article in *British Medical Journal* of same date.)

HUNTER MACKENZIE.

**DAVIS, HENRY** (Tuam).—**Remarks on Rötheln.** *British Medical Journal*, October 8, 1887.

FROM his experience of an epidemic, the author enumerates the following distinctive appearances of the disease :—

1. Slight sore throat; without *malaise*, eruption, desquamation, and sequelæ.

2. Severe sore throat, with moderate fever, rheumatic pains, sometimes desquamation of the hands and fingers, a liability to chronic glandular enlargement (frequently sub-occipital), but no eruption.

3. Symptoms similar to the last, with patches of rose-coloured miliary eruption, generally on the limbs, sometimes extending over the trunk and face, uncertain in duration; sometimes decidedly itchy, and often followed by brawny desquamation.

4. Considerable fever, some coryza, cough, aggravated sore throat, a general eruption somewhat like scarlet fever, with scarlet tongue; desquamation, branny on the body, in whole pieces from the hand.

5. Ushered in by severe rigors and vomiting, or even by convulsions and protracted unconsciousness. Eruption in form of purple blotches; foul tongue, with red papillæ projecting; acute sore throat, with regurgitation of liquids through the nose; distressing cough; great prostration; desquamation, both branny and in pieces; a tendency to dropsy and to chest complications.

As results of rötheln, there may be delicacy of the throat, and chronic enlargement of the tonsils; chronic enlargement of many sub-occipital and cervical glands, two or more of which may unite to form a considerable swelling.

HUNTER MACKENZIE.



## ASSOCIATION AND CONGRESS MEETINGS.

### Ninth International Medical Congress.

#### SECTION OF LARYNGOLOGY.

*Inaugural Address of the President, W. H. DALY, M.D.*

GENTLEMEN,—

It is gratifying to see so many of my American *confrères* here to redeem the pledge made for them at Copenhagen, Denmark, in 1884, that an American welcome should be given the International Medical Congress at this, its ninth meeting. It is also a source of highest pleasure to meet those present from foreign lands, many of whose familiar names in the growing literature of laryngology, remind us that we are not altogether new acquaintances. With many of us our memories revert at this time with renewed freshness and pleasure, to our last meeting in the capital city of the kingdom of Denmark—the home not only of the sturdy Norseman, but of the most accomplished medical scholars; where both king and nation gave up their country to the good of the Congress during its meetings, and where everyone, from ruler to peasant, united in showing their nation's guests what the full meaning of the Norseman's hospitality was—so earnest, so quiet, so restful, so complete that it comes back to us at the end of three years as though it was a quiet happy dream of ours in a Norseman fairyland. We scarcely think it is possible for us to be so successful, but if we can secure a degree of the happiness and profit realized by all of us in Denmark, in 1884, then I think we shall have been successful indeed. To one and all, however, not only to personal friends from across the seas, whose familiar faces I observe before me, and to whom I am so much indebted for early and valuable training in laryngology, but to all I bid a heartfelt greeting and cordial welcome; and though we may not attain the perfection of the great meeting in Copenhagen in 1884, yet I beg all of you to feel that the broad bosom of this beautiful land is happy in being your resting place, and its people feel the high honour that is accorded them in being permitted to entertain the worthy representative medical men from foreign nations. We sincerely trust that none of you will leave this, our nation's capital, without inspecting its residential localities, as well as its public buildings; the National Museum; the Museum of the Army; the Smithsonian and other institutions. None of these collections suffer by comparison with the famous collections

of the Old World. In fact, Washington City is placed in the front rank as a repository of scientific learning. We ought to congratulate ourselves as laryngologists, upon this our second meeting, as an independent section of the International Medical Congress, and endeavour to have the work of this branch of medicine allotted a special place in every large medical body, as the importance and growing excellence of its literature and valuable practical work deserve. When one looks back on the state of laryngology in 1876, and makes a comparison with its present status, it becomes a matter not only of the utmost interest, but of satisfaction and pride, to those who have been engaged in its study and advancement, to note what its cognate branch, rhinology alone, has done for the successful and rational treatment of hay fever. Before the appearance of a paper which I read before the American Laryngological Association, in 1881, calling the attention of the profession to some observations I made during a few previous years, upon the local predisposing intra-nasal causes of this disease, the sufferers therefrom had spent a rambling sort of life, seeking immunity from what they can now, in a large percentage of cases, easily obtain cure, permanently and surely at home, by a proper rational treatment. I desire to say, however, that the lamented Hack, and some other able workers in the same field, claimed more for the plan of treatment I then advised, than I ever did, as I then, in 1880, merely postulated my opinion. I still find it, after seven years, strongly tenable, viz., "Whether we are warranted in believing any case of hay fever purely a neurosis, without first eliminating the possible causation due to local structural or functional disease in the naso-pharynx." Therein clearly admitting that a proportion of cases were of the character of neuroses, but a far greater proportion still depended on a chronic intra-nasal disease, upon which the exciting cause, viz., pollen and other agents, acts with effect, and, without this intrinsic nasal disease the exciting cause is innocuous. I am firmly of the belief that the workers in our special branch will yet make the local treatment so complete that we shall cure still a larger percentage, even all the cases of hay asthma that present themselves. This is a hopeful and zealous view of the future of hay fever, but I nevertheless expect to see it realized.

There are few laryngologists but have constant opportunity of observing the rapid development and growth of puny children after having been under the treatment of the throat specialist, and their noses and throats put in proper order, ensuring that the filthy catarrhal discharges are no longer swallowed, and the upper air-passages are

opened, so that during sleep they can get a plentiful supply of air, hence physical thrift and comfort quickly change the weakly constitution to a strong one. I think no working laryngologist can fail to note the growing importance of rhinology, and I am free to say that the opinion I expressed in a paper which I read before the eighth International Medical Congress at Copenhagen—viz., “that the laryngologist of the future must be more the rhinologist, and the rhinologist more the surgeon than the physician”—has been fully borne out by the evidence afforded by our literature alone. There can be no question that a large proportion of the inflammatory diseases of the larynx are secondary to an initial disease of the intra-nasal cavities of like inflammatory character. This I have repeatedly verified by years of observation, and frequently publicly stated in our deliberations, and I am pleased to say that the number of my colleagues who have since also verified this to their own satisfaction, is an ever-increasing one, including some of the most successful and distinguished practitioners in this special branch of medicine. The aid modern rhinology has been in our successful prevention and treatment of internal and middle ear disease alone, is scarcely calculable. The fact is apparent that no aurist can be accomplished in his special work who ignores the facilities afforded him by a careful study of the concomitant and too often initial disease of the intra-nasal cavities. But, gentlemen, time passes, and I must not further dilate on the advancement of our beloved specialty and its cognate branches, but the bright minds who are now devotees of the service and future workers will place it higher and higher, till it reaches its zenith of excellence and usefulness to humanity. As you observe by the printed programme there is an abundance of papers by able writers from many lands, upon most attractive subjects, and the valuable time of the section must not be taken up by either your President or any else, to the exclusion of others. I will therefore set the example of brevity by making my address short. I feel that I have your kind wishes, and that you will aid me in expediting the work of the section from day to day, adhering yourselves strictly to the time permitted to each member under the rules, viz., twenty minutes for the reading of a paper, and ten minutes for each speaker engaging in the discussion thereof. I shall hope that each member will be promptly here at the hour to which we adjourn, so that we can begin our work and continue it without undue haste as the session advances. But, friends, we are solemnly reminded in these living moments, as we enjoy our happy greetings of old friends and new, “From lands

of sun to lands of snow," that there, too, is an increasing number of the goodly names of our honoured dead, who worked and won fame in the fields we now cultivate; while they are personally the silent members of this, our ninth International Medical Congress, yet through every one of you their names and voices, and words of wisdom will be heard as you speak at this, for the time being, "The World's Medical Forum," to your absent colleagues in every land and clime. Their names are on the lips of every student of laryngology, and their words will always stand a part of its growing and valuable literature; and while their fame is our pride, let it also be our aim to emulate the higher traits of character, and the ability that won for our Elsburg, Krishaber, Foulis, Bruns, Waldenburg, Burow, Böcker, and Hack, the distinction that made their teachings as beacon lights to guide their less-gifted brethren in the fields of laryngological science. Oh, honoured dead, we in spirit strew flowers on your tombs, and join hand in hand, while we bless the memory of your worthy lives and mourn the events of your too untimely deaths. A part of this number were young men cut off in the growing beauty and strength of manhood, with all the zeal and enthusiasm of their scientific labours still fresh upon them. May the earth rest lightly over them in the respective lands where their devoted bodies lie,—the lamented, the honoured dead of our ranks. (THE AUTHOR.)

*The Diagnostic Differentiation of Recent Tuberculosis, Specific, and Rheumatic Laryngeal Disease.* By Dr. E. L. SHURLY (Detroit).

THE differentiation of recent tuberculous, specific, and rheumatic disease affecting the larynx, as we all know, is a topic of very wide range. I shall endeavour, however, to present the subject as concisely as possible, by confining myself rigidly to the laryngeal region. You will therefore notice the omission of many things which, were time and circumstances favourable, might be included. While there is much similarity in the symptomatology of the three diseases whose local expression we are about to consider, there is that variation in even typical cases which will allow very often of distinction. Without further generalization, I will call your attention, first, to the laryngoscopic appearances; second, to the objective symptoms; and third, to the systemic symptoms accompanying the three diseases. *Hyperæmia, or congestion, and inflammation of the laryngeal mucous membrane* is, of course, one of the earliest manifestations in each of the conditions under consideration, unless we may sometimes except phthisis. In recent syphilis—whether secondary or tertiary—it is apt to be diffused and persistent, the colour varying according to the individual. In phthisis, although a majority of cases present a paleness of the



mucous membrane, yet this may soon be succeeded by congestion, more or less diffused. In rheumatism, when the hyperæmia is general, it seems less intense, and more disposed about the upper larynx, especially in the muscular variety constituting rheumatic laryngitis; while in the arthritic form the congestion seems to take place at first along the lateral wall up as far as the faucial pillars, either in streaks or quite diffused. The surface is not granular, as is the case sometimes with either of the other diseases. *Anæmia*—the opposite condition—rarely occurs in recent diseases of either affection excepting *phthisis*, unless as an œdema, which may then accompany either syphilis or rheumatism, especially the latter, if an active inflammation be seated in one of the arytenoid joints. *Tumefaction or infiltration*, either quickly or slowly, succeeds congestion in tuberculous laryngeal phthisis, although not always. All of us have, I think, met with cases of tuberculosis where the tumefaction was quite diffuse, and beginning even in the lower larynx, which seemed more like real hyperplasia than mere infiltration? Of course, when the characteristic swelling of the arytenoid eminences and epiglottis—so common in this disease—is present, the diagnosis is about determined. In syphilis, either secondary or tertiary, when recent the tumefaction comes slowly, while the thickening is not so great or regular. The surface may, and often does, show a papular character and very uneven surface, but when certain regions of the sub-mucosa contain the principal exudation a careless inspection might lead one to regard the nature of the case as tubercular. In some cases of rheumatism and gout, especially the latter, the tumefaction is not diffuse, but on the contrary distinctly localized at the posterior part of the larynx on either side, according to the arytenoid joint affected, and is of such consistence in subacute or chronic cases as to appear like an organized hyperplasia. Later on, if the joint undergoes organic change or perichondritis supervene, the thickening becomes firm and corrugated. In my opinion it is very difficult indeed in such cases—early stages—to differentiate between a local manifestation of syphilis and rheumatic gout or gout. In the muscular variety of rheumatism the tumefaction is usually very slight, and disposed in lines or patches. Ulceration soon supervenes in recent tuberculous disease, and less rapidly, as a rule, in syphilitic; while never in rheumatic, excepting in advanced states of rheumatic perichondritis. Regarding syphilis, it is considered doubtful by many observers if condylomata, gummata, or ulceration ever occurs in the larynx early or primarily; while, on the other hand, there are cases reported in medical literature with descriptions of such appearances. When



ulceration occurs it comes on quickly and often symmetrically, the ulcers are solitary, deep, with sharp cut edges, irregularly round, surrounded by a bright areola of congestion and swelling, and having a predilection for the ary-epiglottic folds and upper surface of the epiglottis. It is, however, very rare to find ulceration in recent syphilitic disease, primarily occurring in the larynx. The ulceration of laryngeal phthisis or tuberculosis comes on slowly; it is more apt to occur primarily in the larynx than in the structures above. The ulcers are small, numerous, scattered, superficial, edges irregular, in some cases described as like worm tracks, while in others smooth oval excavations, generally seated on the under side of the epiglottis, arytenoid and ary-epiglottic folds, ventricular bands, and less frequently on the vocal cords. It has been said that tubercular deposit might be recognized in the edges of the ulcers of some cases.

Of course there are many departures from the typical appearance, as for instance, when the case is a mixed one, then the ulceration may be rapid and serpiginous, or deep and confluent, even in the early stages. I remember a case of this sort in my own practice with well-marked ulceration, confined to the larynx, and with a history of both tuberculosis and syphilis, which went on from congestion to extensive destruction of the laryngeal membrane in two weeks. *Laryngeal hæmorrhage* is rarely a symptom of laryngeal phthisis or syphilis, excepting as a result of erosion, but it is sometimes an accompaniment of rheumatism. The *mobility* of the parts may very early suffer impairment in the course of these diseases, whether syphilitic, laryngeal, or rheumatic. Immobility of one or both cords would be due either to tumefaction, hyperplasia, or paralysis. The immobility due to rheumatism can be easily confounded with paralysis or immobility from totally different causes—as when a rheum-arthritis affects one of the arytenoid joints. The distinguishing feature, aside from the history, in cases where the articulations are involved, is the location of swelling or fulness toward the base of the cartilage and about the attached portion of the ventricular bands, together with the pain of laryngeal and neck muscles; and when the laryngeal muscles are the seat of the trouble, the swelling may be insignificant and the mobility be incomplete, but the pain and soreness are excessive.

The *objective symptoms* belonging to the early stages of these diseases may be mentioned as hoarseness, aphonia, odynphagia, dysphagia, pain in the throat and adjacent region, cough, secretion, and expectoration, varying in degree according to the case. Hoarseness is generally present in laryngeal hyperæmia from any cause—unless confined to the upper part, and is due to the different conditions

of tumefaction affecting the sub-mucosa, inter-arytenoid fold, or may be functional. Though generally present, it is not invariable in recent tuberculous or syphilitic disease; but dysphonia—especially accompanied by soreness of the neck—is a marked symptom of rheumatism; in gout, however, the pain and soreness are more limited, and less fugitive than in the acute or sub-acute variety of rheumatism. Cough of peculiar character is almost always present in syphilis and laryngeal phthisis, but not so in rheumatic disease, except perhaps the occasional attempts at clearing the throat, which hardly amount to laryngeal cough. Waiving any remarks upon the secretions of the mucous membrane in syphilitic and tuberculous disease with which all are familiar, I would state that in rheumatic it is usually glairy—excepting in gouty cases associated with more or less bronchial catarrh, when it is muco-purulent. Microscopic examination of sputum never shows bacilli or elastic tissue, excepting cases complicated with chronic bronchitis. The *shortness of breath* which I have seen mentioned as one of the signs of rheumatic laryngitis, occurs only in those cases where there is mechanical obstruction from tumefaction, immobility of the glottis, or concomitant bronchial catarrh; occasionally it may depend upon implication also of the muscles of respiration. In the other two affections it is, of course, due to structural changes. Odynphagia and dysphagia occur early in rheumatism, but later in syphilis and tuberculosis. *Spasms of the glottis*, while occurring at times in laryngeal phthisis and syphilis, is much more frequent in the early stages of rheumatic disease, but after a time if the disease becomes general this symptom disappears. Chorea of the vocal cords may also be the principal symptom of rheumatic disease. The *clinical history* connected with these manifestations is certainly an important factor in the diagnosis, and oftentimes must be our main dependence in differentiation. In some of the mixed cases, such as present a clinical history of all three of these diseases, differentiation in the earlier stages becomes almost impossible.

Concerning the rheumatic affection, which is not as common as the others, I think we ought to recognize two varieties at least—the one a genuine arthritis occurring in a gouty subject, perhaps with the local lesion confined to the neighbourhood of the joint mainly; and the other seated for the most part in the nervo-muscular apparatus of the larynx, and also affecting the neck or chest muscles more or less; in both forms the attending pain in the parts and neighbourhood is apt to be severe. In conclusion, permit me to offer a summary, in the form of a tabular statement, of the marked signs of each of these diseases:—

TABLE SHOWING PRINCIPAL SIGNS AND SYMPTOMS OF RECENT TUBERCULOUS, SYPHILITIC, AND RHEUMATIC DISEASE OF THE LARYNX.

LARYNGEAL PHTHISIS.	SYPHILIS.	RHEUMATISM.
<i>Hyperæmia</i> or congestion often not so marked.	<i>Hyperæmia</i> and congestion always persistent and extended.	<i>Hyperæmia</i> and congestion always present, but not intense and often localized.
<i>Tumefaction</i> or infiltration quite constant and peculiar, affecting epiglottis and arytenoids.	<i>Tumefaction</i> not marked.	<i>Tumefaction</i> rare excepting in arthritic rheumatism, when it is local.
None.	<i>Condylomata</i> and <i>gummata</i> sometimes.	None.
<i>Ulceration</i> , common, slow development, scattered, irregular, small, roundish or oval, commonly situated on under surface of epiglottis and arytenoids.	<i>Ulceration</i> may be rapid, but rare in larynx. When occurring is rapid and apt to be solitary or symmetrical, surrounded by areola.	<i>No ulceration.</i>
<i>Mobility</i> of cords slightly affected.	<i>Mobility</i> slightly affected.	<i>Mobility</i> out of proportion to structural change, especially arthritic variety.
<i>Hæmorrhage</i> rare.	<i>Hæmorrhage</i> very rare.	<i>Hæmorrhage</i> common.

OBJECTIVE SYMPTOMS.

<i>Hoarseness.</i>	<i>Hoarseness</i> , <i>Dysphonia</i> slight.	<i>Dysphonia</i> , <i>Aphonia</i> , or <i>Hoarseness.</i>
<i>Dysphagia</i> and <i>Odynphagia</i> only when epiglottis and arytenoid eminences are principally affected.	Not marked unless pharynx is involved.	Quite persistent and constant.
<i>Pain</i> in larynx absent.	<i>Pain</i> of larynx absent.	<i>Pain</i> in larynx quite constant, and about neck.
<i>Expectoration</i> of mucus containing bacilli often.	<i>Expectoration</i> of mucus, no bacilli.	<i>Little or no expectoration</i> , no bacilli.
<i>Cervical glands</i> not enlarged.	<i>Cervical glands</i> enlarged.	<i>Cervical glands</i> not enlarged.
No <i>Spasm</i> of laryngeal muscles, as a rule.	No <i>Spasm</i> of laryngeal muscles.	<i>Spasm</i> frequent, also chorea.
<i>Sensation</i> not perverted.	<i>Sensation</i> not perverted.	<i>Sensation</i> often perverted, paræsthesia.

(THE AUTHOR.)

*On Primary Erysipelas of the Larynx*, by Prof. F. Massei (Naples).—Erysipelas of the larynx is a morbid condition of which we find notice taken by several authors, and even the primary form has been recognized, although considered by all to be a very rare disease.

To the names of Bayle, Porter, Sestier, Leudet, Türck, Redcliffe, Campenon, Bryson, Delavan, Charazac, Strümpell, etc., we must add Ryland, who, in 1837, gave a very exact description of erysipelas of the larynx. In 1885 the author called attention to an affection of the larynx, which has all the clinical features of erysipelas, and which occurs primarily, and is not rarely met with. From a diligent study of the symptoms the author feels convinced that many cases of so-called "phlegmonous laryngitis" are really erysipelatous, and he differentiates two forms—1. In which local symptoms and fever are predominant; 2. A form in which collapse is common. The process may at a later stage extend to the lungs and the pharynx without the least appearance of any external manifestation in the skin, and the author, if not discovering a new disease, has thus enlarged the knowledge of laryngeal erysipelas by narrowing the general conception of phlegmonous laryngitis—up to the present there is only clinical evidence of the condition. It is necessary, however, to establish bacteriological experiments by the cultivation of the streptococcus. On the living subject affected with the symptoms of laryngeal stenosis, this is not easy to perform.

The author does not wish it to be inferred that he denies the existence of acute epiglottitis from burning, primary cedema of the larynx in the course of nephritis, or angioneurotic laryngitis (Strübing), but he maintains that those cases in which there is considerable swelling of the epiglottis and ary-epiglottic folds, having the property of migrating from one part to another, and giving rise to stenosis and dysphagia, and accompanied by fever, of anomalous and relapsing character, and usually high (40° C. or more), along with a pain in the external parts (from lymphatic involvement), are to be considered as belonging to the order of erysipelatous affections. The author strongly recommends ice internally and externally, spraying with sublimate (1—2,000), tracheotomy, if necessary, artificial feeding by Dujardin-Beaumez's apparatus in case of severe dysphagia, quinine internally, and stimulants if any danger of collapse. In old people the prognosis is very bad. In cases where tracheotomy is called for, it should be neither hastily nor too speedily performed.

(AUTHOR'S ABSTRACT.)

**Twelfth Congress of Italian Physicians and Surgeons.**

*Held at Pavia, September, 1887.*

**SECTION OF LARYNGOLOGY AND OTOTOLOGY.**

THESE two subjects, though included in the same section, were placed in sub-sections, each with its own officers. Professor Massei was elected by acclamation President of the Subsection of Laryngology; Dr. O. Masini, Vice-President; and Dr. G. Masini, Secretary.

Dr. PALADINI (of Empoli) related an interesting case of *Foreign Body* (a small stone) lodged in the Right Bronchus of a boy eight years old, and for which tracheotomy was performed. In order to facilitate the removal of the foreign body, Dr. Paladini contrived a cannula (like Ferguson's cannula) the blades of which could be separated and held in position by a rigid spring.

Prof. MASSEI remarked on the application of this cannula for removal of morbid products as well as foreign bodies.

Dr. KRUCK demonstrated several specimens of *Adenoid Vegetations*, and related observations, showing the relative frequency of these neoplasms in Lombardy. The disease is very rare, as a general rule, in Italy. A discussion was maintained by Drs. O. and G. Masini and Massei.

Prof. COZZOLINO made critical observations on *Psoriasis of the Tongue and Mouth*, and praised the galvano-cautery as a method of treatment.

Prof. MASSEI related his views upon *Primary Erysipelas of the Larynx*, the importance and symptoms of which have not been sufficiently understood. He also is of opinion that up to now, there is no anatomical confirmation of the condition, and Cozzolino, and G. and O. Masini, have, moreover, shown how easy it is to mistake the streptococcus of erysipelas, and how necessary it is to cultivate these bacilli before drawing conclusions.

Dr. G. MASINI discussed the *Treatment of Hyperplastic Laryngitis by Scarification, Cauterisation, and Lactic Acid*. He insisted on the great importance of Labus's method of scarification "scorticamento delle corde" as a means of treatment, or the necessity of relying upon more than one method of treatment. He has not derived much satisfaction from the employment locally of lactic acid.

Prof. O. MASINI read a paper on *Colloid Degeneration of the Mucous Glands of the Larynx*. The paper was very interesting, and should be read in the original. In a special case related by the author, the cause of the degeneration was an acute inflammation consequent upon arsenic poisoning.

Dr. G. MASINI spoke of *Some Rare Manifestations of Syphilis in the Larynx*, insisting upon the form of "gummatous syphilide of the cords," described by Massei. He has found treatment by intra-muscular injections of calomel very efficacious, and regards them as superior to injections of corrosive sublimate. The beneficial result is obtained much more quickly.

Prof. O. MASINI recently having examined a case of *Cystic Tumour of the Vocal Cord* (from a specimen in the Pathological Museum of Genoa), concluded that it arose in this case from imperfect glandular formation, and is of opinion that another method of cystic formation is possible, approaching to Cohnheim's ideas of neoplasms.

MASSEI spoke of the production of sanguineo-cystic tumours, the characters of which can only explain the short time in which the voice is lost and breath impaired.

Prof. COZZOLINO presented and described his well-known nasal inhaler for treatment of affections of the upper air-passages.

Dr. FERRERI read a paper on the *Treatment of Papillary Growths in the Larynx*,



demonstrating the advantage of cutting spoons as originated by Prof. de Rossi, of Rome.

MASSEI praised the idea, and pointed out that some infiltrated tumours cannot be removed by common forceps, but de Rossi's spoon did not appear to him to be very useful, and he preferred Hering's instrument—the same instrument recommended by this author for the treatment of laryngeal phthisis.

G. MASINI feared the falling of small pieces of the tumour, when the instrument is fenestrated.

O. MASINI thought that de Rossi's instruments must be much improved before they can be of practical value.

Prof. O. MASINI communicated a case of *Laryngeal Syphilis*. Simple inspection was not sufficient to give an exact diagnosis. The history of the case rendered it certain that it was a syphilitic process, under the form of infiltration of the mucous membrane, along with cricoid perichondritis, which, however, had nothing to do with the former affection.

Prof. O. MASINI read also a paper on *Neof ormation of Lymphatic Vessels in the Larynx*. The author is of opinion that this neof ormation differs from a similar process of the blood-vessels, which, as is well known, are reproduced by buds and prolongations. In cases of inflammation, and in consequence of this process, the lymphatic vessels disappear after the blood-vessels; in other words, when the neoplastic tissue has advanced to a high degree of development, the lymphatics lying in the connective tissue acquire all the characters which properly belong to the recognition of blood-vessels.

Prof. MASSEI read a paper on the *Local Treatment of Laryngeal Phthisis*, in which he maintained that the local cure of a tubercular ulceration does not mean the cure of tuberculosis, and since most cases end fatally he is always very sceptical as to cure. He upholds the great advantages of iodoform and cocaine, and lays down three interesting suggestions as to treatment, viz., 1. Extirpation of the larynx in which primary tuberculosis can be diagnosed with certainty (cases which, however, the author admits are extremely rare); 2. Inhalation of "bacteria" which can be proved to be antagonistic to Koch's bacilli; 3. Sub-mucous injections of sublimate (1 in 2,000).

Dr. G. MASINI read a paper upon *A Case of Isolated and Complete Paralysis of the Arytenoid Muscle*. This, the first case reported in Italy, occurred in a hysterical woman, who had lost her voice from catching cold. The voice was restored by the local application of electricity, but she became hoarse again, and after two or three months of topical treatment, the voice was again restored. The author is of opinion that the arytenoid muscle is a constrictor and not a dilator (Moure), a fact which he has had occasion to observe experimentally.

Dr. BOBONE (San Remo) contributed an essay entitled *Hereditary Syphilis, with severe Lesions of the Skin, Tongue, Velum, Ear, Larynx, and Stenosis of the Trachea*, occurring in a cachectic young girl of sixteen. The case was very interesting. The most serious lesions were in the tongue. Under a specific treatment the patient greatly improved.

Prof. V. COZZOLINO presented a paper on *Ozæna and Chronic Rhinitis, and their Treatment on a surgical basis*.

The fundamental principles of this method are as follows:—It is not possible to radically treat chronic inflammations of the nose, unless with the galvano-cautery or scarification. The transformation of the mucous membrane of the nose into myxomatous and colloid tissue is well-known, a fact supporting this contention. Operations are rendered more easy by previous application of cocaine, and applications are to be carefully made to those parts in which the degenerative process is evident (the posterior extremity of the turbinated bodies).

Dr. G. MASINI read a paper on *Cortical Motor Centres of the Larynx*. These experimental and clinical studies were conducted in the Physiological Laboratory at Florence, under the direction of Professor Luciani, and his conclusions are—  
1. There is a region on the cerebral cortex of the anterior portion of the hemisphere which, in the dog, presides over the movements of the glottis. 2. This region extends over the whole motor zone, but its most active spot is at the base of the so-called pre-frontal convolution or laryngeal centre of Krause. 3. It is neither isolated nor distinct, but merges into the other motor centres for the pharynx, tongue, and velum. 4. Lesions of one side give rise to paralysis of the opposite side of the larynx, with affection of sensibility of the mucous membrane. 5. Bilateral lesions produce diminution of sensibility and movement, which is accentuated and persistent without reaching a degree of true paralysis. 6. Other subcortical centres must be admitted, and in this manner we can explain the perfect compensation after lesions of one side, and of failure of complete paralysis when there is a bilateral lesion.

The author's clinical conclusions are—1. In the cerebral cortex (anterior hemisphere of man) there is a centre presiding over the glottic movements. 2. It occupies, probably, a portion of the third frontal convolution, near to Broca's convolution, and the base of the ascending frontal. 3. Lesions of this centre give rise to persistent glottic paralyses (aphonia, hoarseness, diphthonal voice). 4. Motor paralysis is connected with sensory paralysis.

Other papers read at this Congress (in other sections), of interest to laryngologists were :—

*The Treatment of Tuberculosis*, by Prof. DE RENZI.

*The Direct Treatment of Tuberculosis*, by Prof. RIVA.

*Prophylaxis of Diphtheria*, by Prof. COZZOLINO.

*Erythema Nodosum with Laryngeal Localisation*, by Prof. BREDÀ.

*Results of Tracheotomy in Diphtheria*, by Dr. FERRARI.

Abstracts of these papers will appear at another time, as they are published.

The Section of Laryngology and Otology concluded with the general expression of the necessity of uniting laryngologists generally into one common association in Italy. The President remarked upon the necessity of assuring a competent number of members devoted to the pursuit and publication of serious work.

MASSEI.

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## REPORTS OF SOCIETIES.

### Central London Throat and Ear Hospital.

November 14, 1887.

*Benign and Malignant Growths of the Larynx*.—A Clinical Lecture delivered by Mr. LENNOX BROWNE.

THE author prefaced his remarks by stating that he was prompted to speak on this subject because it was largely occupying the public mind at the present moment, and it was, therefore, one concerning which it was very necessary and desirable to give some accurate information, but at the outset he disclaimed any intention of impertinently interfering with a case he had not seen, far less of speaking in a spirit of jealousy or cavilling criticism which might be calculated to harass those charged with a terribly anxious responsibility.

Benign growths of the larynx were divided into three classes : 1, those which once removed did not recur ; 2, those which recur, but in which the recurrent element is not strongly manifested ; 3, those in which the recurrence is so persistent

as to practically constitute a local malignancy, without, however, infecting the system with the elements of a fatal constitutional disorder.

Benign growths were stated to be rare, and to occur in not more than one per cent. of chronic laryngeal disease. The commonest primary cause was active congestion of the mucous membrane, and at least half the cases on record occurred to those whose occupation obliged them to exercise their voice professionally. With regard to treatment it was insisted that many small growths might be reduced by astringent applications, and that all should, as far as possible, be removed by instruments so guarded as to be incapable of wounding healthy tissue. Such injury was believed to be a not infrequent cause of malignant degeneration of growths which were primarily benign, and Mr. Lennox Browne had been the first to draw attention to this fact so long ago as 1875. The proposition had met with opposition in one or two quarters, but it had been again brought forward prominently during these last few days, as if it were something new: evidence appeared to be accumulating in confirmation of the correctness of the lecturer's conclusions on this subject, and doubtless they would soon be generally accepted. The distinction between benign and malignant growths was carefully elaborated, as well as the varieties of malignant formations, such variations denoting varying degrees both of local malignancy and of constitutional infection. The prospects of cure of various operations for removal of those of the graver kind were considered in detail.

In justification of those who advise delay of radical treatment by excision, statistics were given to show that while an enormous percentage of such cases have a rapidly fatal issue, in none is there any recovery of voice or anything more than prolongation of a few years of life of considerable discomfort. No physician would dream of advising such a hazardous procedure so long as microscopic examination showed the disease to be of an innocent nature. The milder operation of tracheotomy, while less immediately fatal, possesses all the advantages as to extension of life, and a minimum of the dangers and miseries of so-called radical extirpation.

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THE CASE OF  
HIS IMPERIAL HIGHNESS THE CROWN PRINCE OF  
GERMANY,

FROM THE TIME OF HIS VISIT TO ENGLAND TILL HIS ARRIVAL AT  
SAN REMO.

BY SIR MORELL MACKENZIE.

(From Notes supplied by Dr. NORRIS WOLFENDEN and  
Mr. MARK HOVELL.)

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AFTER the removal of the growth last summer, and the subsequent application of electro-cautery, no recurrence of the growth took place. Some general congestion of the larynx remained, and whilst His Imperial Highness was in the Isle of Wight a slight thickening of the mucous membrane on the posterior surface of the arytenoid cartilages near their base was observed by Dr. Norris Wolfenden, at that time in daily attendance on the Crown Prince. At one of my weekly visits I verified Dr. Wolfenden's report, and perceived that the thickening presented the form of a ridge raised to the extent of about a millimètre, of yellowish colour, and extending horizontally from the outer border of one cartilage to that of the other. The action of the left vocal cord, which had been noticed in Berlin to be slightly impaired, continued in the same state. It should perhaps be here mentioned that soon after His Imperial Highness arrived in England a marked disposition to

catarrhal inflammation of the larynx and trachea, or fugitive congestion, was observed. A rather sharp attack occurred in the Isle of Wight, and this was followed by general relaxation of the mucous membrane of both the pharynx and larynx.

The congestion disappeared whilst the Crown Prince was in the Highlands; and during this period the thickening at the base of the arytenoid cartilages already described was absorbed. On the return of His Imperial Highness to London, the condition of the larynx was on the whole satisfactory; the movement of the left vocal cord was much more free, and the voice strong, though not quite clear, owing to a slight increase in the congestion having taken place on leaving Braemar. The Crown Prince's general health was excellent.

On September 9 a slight thickening was noticed on the posterior extremity of the left vocal cord, which increased for a few days, and then gradually disappeared, being on the 18th no longer visible. For a few days previous to the development of this thickening, the larynx generally had again been more congested. On September 13, Dr. Evans, of Paris, extracted the Crown Prince's left lower second molar tooth, which was much decayed, the fangs showing the result of a considerable amount of periostitis.

On September 14, an oblong thickening of the mucous membrane, about five millimètres in length and three in width, was observed by Mr. Mark Hovell nearly half an inch below the middle of the left vocal cord, and parallel with its free border. Mr. Hovell states that this swelling gradually increased in size, and when seen by me on September 22 it was nearly round, and measured rather more than half a centimètre in diameter. Two days later the Crown Prince took cold, and on the following day complained of a sense of fatigue, disinclination to take food, and great sleepiness in the daytime. On examining his throat, the left aryepiglottic fold was found to be oedematous. His temperature was 101° F. In twenty-four hours the oedema had entirely disappeared, and the temperature had become normal. Although the oedema was apparently due to cold, the possibility of its being caused by limited perichondritis was discussed at the time. The acute swelling had no apparent effect on the little thickening below the left vocal cord, which gradually became smaller, but did not entirely disappear.

The Crown Prince continued to enjoy good health after his arrival at Baveno, and when I left Italy everything appeared satisfactory, though slight general congestion remained, as well as the thickening referred to previously. On the evening of October 17, Mr. Mark Hovell noticed a marked increase in the congestion of the larynx, both vocal cords being of a bright red colour. During the next few days the congestion decreased; but on the 21st the hyperæmia again increased in intensity and was more diffused. On the 27th an increase was noticed in the size of the thickened surface beneath the left vocal cord, and at the same time slight general tumefaction of the left side of the larynx appeared. During the next few days the thickened surface slightly increased, and on the 31st the surface was seen to be irregular, and in one place there was a distinct spur or projection. The next day superficial ulceration of the new formation was noticed, and the left vocal cord was seen to be slightly swollen along its free edge. On the 28th the voice of His Imperial Highness was quite clear; and, indeed, in the opinion of the Crown Princess, was perfectly natural, but since this date the Crown Prince has been much more hoarse. On October 30 a slight reddish projection was noticed beneath the *right* vocal cord; this remained stationary for two or three days, then disappeared, and formed again on November 5. On November 1 a slight enlargement of the left submaxillary gland was noticed, and this subsequently increased in size.

On November 3 the new formation had further enlarged, and was now rather



more than a centimètre in diameter, and raised to the extent of about four millimètres. The extension of the growth since it was first seen had always been upwards. On the morning of the 4th a very slight œdema was noticed at the base of the left arytenoid cartilage, which disappeared in the evening, and was again present on the morning of the 5th.

On the following day I arrived, and found the state of the larynx such as Mr. Hovell had described to me. On the afternoon of the 8th, intense œdema of the mucous membrane covering the left arytenoid cartilage was noticed, and in the evening the œdema involved the entire fold, which was tense and red. On November 9 the patient was examined by Professor Schrötter and Dr. Krause, but, owing to the œdema, it was impossible to obtain a complete view of the new formation at the lower part of the larynx. On November 10 the patient was again examined by the same physicians, and also by Dr. Moritz Schmidt; the œdema was already much diminished, and a good view could be obtained of the whole of the larynx.

In my opinion, the œdema is due to limited perichondritis, which in its turn has probably been set up by the growths which have been formed from time to time in the larynx. Although the nature of the growth which has lately appeared has not been determined by microscopic examination, it presents every appearance of cancer.

The above report is published by the wish of His Imperial Highness the Crown Prince of Germany. A copy of it was sent to the *Berliner Klinische Wochenschrift* on Monday.

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The following remarks were appended by the editor of the *British Medical Journal* :—

In the above report we may be allowed to call special attention to the following points :—1st. The occurrence on the posterior surface of the arytenoid cartilages of a deposit, which was after a time absorbed; 2nd. A swelling taking place at the site of the old growth and then disappearing altogether; 3rd. A swelling forming under the left vocal cord which first increased, then receded, and subsequently formed the base of the new growth; 4th. A swelling, or growth, under the right vocal cord. The formation of these growths, and the total absorption of some of them, with the retrogression and subsequent development of others, points to the probability of the fact that chronic inflammation has played a considerable part in the development of the disease. It is no doubt this feature which has masked its malignant nature. It is noteworthy that the deep-seated cervical glands are not affected in this case (the superficial glands seldom are involved in malignant disease of the larynx). There is now slight swelling of the submaxillary gland, but this has only recently been observed, and is of little significance in the absence of any secondary enlargement of the lymphatic glands. That a case of cancer of the larynx should run ten months without any ulceration, except such as was produced artificially by electric cautery and operation with the laryngeal forceps is also remarkable; indeed, the healing of the wounds thus caused would seem to indicate that the affection in its early stages was not of a cancerous nature.

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This report was published in the *British Medical Journal* of November 19, 1887, and was preceded by the following editorial remarks :—

The official confirmation of the sad intelligence which it was our painful duty, on Friday last, authoritatively to announce as to the appearance of an undoubtedly malignant growth in the trachea below the site of that which Sir Morell Mackenzie successfully removed in the summer, has since been promulgated with



the conjoint authority of all the consultants summoned to meet Sir Morell Mackenzie at San Remo. We have now the duty of publishing an official statement by Sir Morell Mackenzie, issued with the highest sanction. We feel, however, that it would hardly be right to publish this document without adding to it two facts which are of importance, in justice both to the illustrious patient and to those who have treated him, concerning certain phases of the early history of the case, about which some misunderstanding appears to prevail, and deplorably incorrect statements have been circulated. These have been made the basis of a still more deplorable polemical discussion. It ought certainly at this juncture to be known, and we are able to state, that when Dr. Hahn, who is the most experienced surgeon in Europe in the matter of the excision of the larynx—and who, it will be remembered, was selected and summoned from Germany for the purpose of performing that operation on a distinguished barrister, now a magistrate of the London police courts—was consulted by Dr. Wegner, prior to the visit of Dr. Mackenzie, in the case of the Crown Prince last spring, he did not recommend an external operation. In view of certain statements which are now being recklessly made on the subject, this is a fact of considerable importance. Further, from the professional point of view, it is right, in view of what has been recently stated, to add that, as soon as Dr. Mackenzie had removed a portion of the warty growth seated on the vocal cord, and Professor Virchow had examined it and pronounced it to be free from any evidence of malignancy, Dr. Mackenzie received the authority of his colleagues in the case to continue his operations by the mouth. Had they withheld that sanction, or been opposed to the continuance of the treatment which was for a time so successful, Drs. Tobold, von Bergmann, and Gerhardt would, of course, have placed their protests on record. Further—and to this also great importance no doubt should be attached from certain points of view—it is the fact that so lately as three weeks ago Dr. von Bergmann stated to a high official on the staff of the Crown Prince, that he considered the course which Sir Morell Mackenzie recommended and pursued in the spring had been the right one. Under these circumstances it ill becomes anyone now, wise as he may imagine himself, with the light thrown by a further development of events, to say that the course originally pursued was not the correct one.

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With reference to the opinion said to have been advanced by Dr. Eugen Hahn, the following correspondence has taken place:—

#### ILLNESS OF THE CROWN PRINCE.

SIR,—I see in the *Journal* of November 19 that the official bulletin concerning the progress of the sad disease of H.I.H. the Crown Prince of Germany, which is published by his wish in your columns, is introduced by some editorial remarks, in which it is stated, among other things, that I had been consulted by Surgeon-General Dr. Wegner prior to the visit of Dr. Mackenzie, and had not recommended an external operation. I give the most unqualified denial of the whole of this statement, and I protest against my name being used in the way it has been done. I have not been consulted by Surgeon-General Dr. Wegner before the arrival of Sir Morell Mackenzie; in fact, I have not even seen Dr. Wegner before May 21, the day of the intended operation, but was asked in a letter by Dr. Wegner on May 20 to be present at the external operation of H.I.H. the Crown Prince in the early morning of May 21, and I agreed to do so.

I expect of your loyalty that you will give this denial the same prominent position which has been accorded to the original statement.—I am, etc.,

EUGEN HAHN, M.D.,

November 19.      Senior Surgeon to the Town Hospital, Friedrichshain, Berlin.

SIR,—I perceive that Dr. Hahn, in the *Times* of November 23, denies the accuracy of a statement which appeared in the *Journal* of November 19, namely, that he had expressed an opinion adverse to an external laryngeal operation in the case of H.I.H. the Crown Prince prior to Sir Morell Mackenzie's first visit to Berlin. That denial, however, must relate rather to some of the incidental circumstances than to the main fact.

I am able to corroborate the statement made in the *Journal* from statements made to me while in attendance on His Imperial Highness in the summer, the source of which was independent of that whence the *British Medical Journal* could derive its information, but, nevertheless, of the highest authenticity.—I am, etc.,

R. NORRIS WOLFENDEN, M.D. Cantab.

19, Upper Wimpole-street, W.

SIR,—In reply to Dr. Wolfenden's letter, I must remain by my statement of November 19, that I have never had the honour of seeing and examining H.I.H. the Crown Prince, and therefore I could not express, nor have I expressed, an opinion adverse to an external laryngeal operation prior to Sir Morell Mackenzie's first visit to Berlin.

I should say that I might be considered the highest authority on what I have said; for Sir Morell Mackenzie's and Dr. Wolfenden's information was, after all, only second-hand, so that a misunderstanding is quite possible.—I am, &c.,

Berlin.

EUGEN HAHN, M.D.

SIR,—I notice that in the *Times* there is a letter from Dr. Hahn, referring to my communication, and in which he says, "I have never had the honour of seeing or examining His Imperial Highness the Crown Prince, and therefore I could not express, nor have I expressed, an opinion adverse to an external operation prior to Sir Morell Mackenzie's first visit to Berlin." Of course, Dr. Hahn is the highest authority as to what he did or did not say, but I remind your readers that the question is not whether he expressed any such opinion prior to Sir M. Mackenzie's first visit, but whether he expressed it at all during the course of the case. My informant received this opinion from no less an authority than Dr. Hahn himself, and though it is quite possible that the matter may have escaped Dr. Hahn's memory, I entertain no doubt that he did in conversation express an opinion decidedly adverse to extra-laryngeal interference in the case of His Imperial Highness the Crown Prince. In doing so I venture to think that Dr. Hahn only confirmed the opinions of those who have regarded him as a careful and judicious surgeon, with a well-earned reputation for the surgical procedure in question.—I am, &c.,

R. NORRIS WOLFENDEN.

Upper Wimpole-street, November 26, 1887.

## REVIEW.

GORDON HOLMES (London).—*History of Laryngology from the Earliest Times to the Present Period. Translated from the English Original by Dr. Otto Koerner (Frankfurt o M). Berlin, 1887 Hirschwald, pag 66.*

THE German reader is under obligation to the translator for having introduced to us this most interesting book, which will not only

interest laryngologists, but will serve as an example of a medico-historical monograph. We wish that the example of Dr. Holmes would be followed for the other special branches of medicine. The book is divided into two parts, one dealing with the two thousand years preceding the invention of the laryngoscope, and the other with the thirty years since that important event. The first part is much the most interesting. The author communicates the views of every one relating to the anatomy, physiology, pathology, and therapy of the larynx. We learn from this book how much good work was done even in early times. The second part contains less that is new to specialists; the history of the invention of the laryngoscope is to be found in every handbook of this science. It is also difficult to write an objective history of the present time. There is often a good deal of space devoted to authors only known in their own country, and of many others nothing is said at all; but, in conclusion, one must admit that it is one of the most interesting books which has appeared for some time.

MICHAEL.

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## OBITUARY.

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### RAFAEL ARIZA Y ESPESO.

THIS eminent Spanish laryngologist and otologist, one of the most studious and illustrious physicians of the age, died at Sagastiechea (Guipuzcoa) on October 13, 1887. He was devoted to the treatment and the teaching of diseases of the throat and ears. Among his Spanish confrères he was considered to be the glory of native medicine, and all who are dedicated to the study of medical sciences pronounce his name with the greatest veneration and enthusiasm. His works upon different subjects in both specialities are many and of great value, and it would be possible to form with them two very complete treatises of laryngology and otology. His vigorous intelligence, genius of observation, just sense, inspired perspicacity, great knowledge, the simplicity and the clearness of his style, his dexterity in operations, and his enthusiasm for scientific advancement shine in his works. He was the first to reveal and describe the polypous form of laryngeal phthisis. His death, which medical Spain now laments, is a misfortune hard to repair. The author of these lines, his best friend, deeply regrets and grieves over it.

SOTA Y LASTRA.

## NEW PREPARATIONS.

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### PINOL. (BURROUGHS, WELLCOME, & Co.)

We have received this preparation, and are of opinion that it is one of the purest in the market. It is distilled from the needles of the *Pinus pumilio*, and is, without doubt, one of the most useful of the essential oil inhalations for the treatment of chronic and subacute laryngeal and pharyngeal conditions.

### EUCALYPTINE. (BURROUGHS, WELLCOME, & Co.)

This is also one of the new and elegant preparations which this well-known firm has introduced to the notice of the profession. Their Eucalyptine is the purest preparation in the market, and can be administered in the same manner as Pinol. Both this and the previously mentioned Pinol can be used either as steam inhalation or for continuous cold inhalation by means of the respirator, and are two of the most effective and pleasant drugs for this purpose in the market.

### HAZELINE. (BURROUGHS, WELLCOME, & Co.)

This preparation has been so long before the public that it scarcely needs any recommendation on our part. Its value in chronic throat and nasal affections is undoubted, and, like all the other new drugs introduced by this firm, it is an elegant preparation. It has already obtained a well-deserved reputation.

### HOUDÉ'S PASTILLES OF COCAINE.

We have received samples of these pastilles, and are convinced that they only require to be better known in this country to insure their general employment in all cases where the use of cocaine lozenges as a sedative in acute inflammation of the mouth and pharynx, and in hyperæsthesia of the mucous membrane of these parts, is desirable. They have the advantage over most other pastilles of the same kind of being pleasant to the taste and certain in their therapeutic action. We can very highly recommend them.

## NOTES.

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**The number** of the *Journal of Laryngology* for January, 1887, being out of print, and only a few copies remaining on hand, the publishers would be grateful to anyone, who, having a copy to spare, would forward it to the office of the *Journal of Laryngology* in London.

**Pertussis in a Cat.**—Mr. O. Bowen, of Liverpool, reports a case. The cat was infected by a boy, and for about two weeks had five or six distinct fits of coughing daily, similar in every respect to those exhibited by the boy, with expectoration of frothy mucous afterwards. Between the attacks the cat was bright and active, though not so much so as before, and lost flesh during its illness. *Journal of the American Med. Association*, June 18, 1887. J. N. MACKENZIE.

**New Journal.**—We have received the first number of a new bi-monthly journal devoted to the interests of laryngology and rhinology, entitled *Archives de Laryngologie de Rhinologie, et des premières Voies, Respiratoires, et Digestives*. It is edited by Dr. A. Kuault, with the assistance of Drs. Bouchard, Verneuil, Cornil, Trélat, and others. We wish the venture success. The first number is an excellent one, and provided successive numbers keep up to this standard, they will prove a valuable acquisition to special literature. We gather that the journal is intended more particularly for the publication of original articles.











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**GERSTS**



